



Jeffrey H. Hopkins, D.D.S.
Vladimir Tismensky, D.D.S.

Date: _____

Introducing _____

Appointment Date: _____ Time: _____

Referring Doctor: _____

Instructions: _____

To Be Filled In By Dentist:

- Patient is having pain, swelling, sensitivity. Please Evaluate.
- Endodontic treatment is necessary for proper restoration of tooth.
- Nerve was exposed.
- X-Ray revealed radiolucency.
- Root Canal treatment was started.
- Post prep is indicated.
- Evaluation for possible apical surgery/implant.
- Retreatment.

	Molars			Right Bicuspid		Anteriors			Anteriors			Left Bicuspid		Molars		
Upper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Lower	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

(circle teeth for endodontic consideration)

Information for Patient:

- You will be returning to your family dentist for final restoration after treatment.
- When calling for your appointment, please have your dental insurance information available.
- Please bring your dental insurance information to your appointment.

Please Mark the Office Where Patient is to be Treated:

- Palos Primary Care Center, Orland Park (708) 460-9191
- Pittsfield Building, Downtown Chicago (312) 629-1600
- Midway Doctors Center, Chicago (773) 229-1700

*The maps of our office locations are on the reverse side
or visit our website at www.orlandendo.com