MATT GEBHARDT, DDS MS, PC
Practice Limited to Endodontics

Date: _____

Introducing: _____

Referring Dentist: _____

Appointment Date: _____ Time: _____

Please circle the teeth or area that may need treatment.

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

- ❑ Root Canal Therapy as indicated
  - ❑ Prepare post space
  - ❑ Place class 1 restoration
  - ❑ Retreatment case
  - ❑ Canals appear blocked
  - ❑ Open apex case
  - ❑ Bleach
  - ❑ Other: _____
- ❑ Surgical Endodontics
  - ❑ Apicoectomy & retrofill
  - ❑ Root amputation, hemisection, bicuspidization
  - ❑ Perforation repair
  - ❑ Trauma—fracture, avulsion, replant, splint
- ❑ Examination, Diagnosis, Consultation

Submit by Email

Print Form

Comments: _____

_____

_____

Office: 541 776-7640 • Fax: 541 776-7630
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www.MedfordEndo.com

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Instructions to Patients:

1. Please call (541) 776-7640 to arrange your first appointment, if not appointed yet.
2. Minors must be accompanied by a parent or guardian.
3. Endodontic therapy is usually completed in one to two appointments. Each appointment is approximately 1-2 hours.
4. Fees are payable at the completion of your first appointment.
5. Please bring this form with you to the appointment.

For additional information visit www.MedfordEndo.com