Dr. Aldo Manzur DDS, MSc, FRCD(C)
Specialist in Endodontics

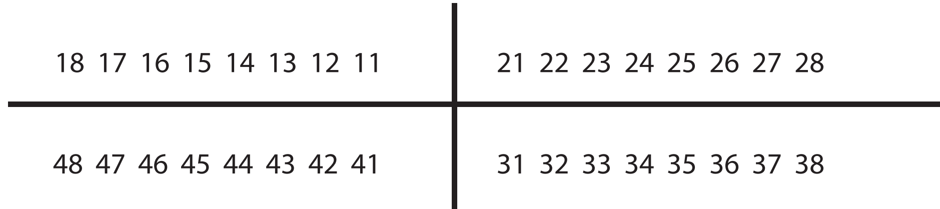
Please ensure all fields are completed

Referring Doctor: ______________________ Office Phone No: ______________________

Patient´s First Name: ______________________ Last Name: ______________________ DOB: (MM/DD/YY)

Address: ______________________ City: ______________________ Postal Code: ______________

Home Telephone: ______________ Mobile: ______________ Email: ______________________ Sex: M / F



Please ensure all fields are completed

Tooth	Consult only	Consult and Treat	Is it Vital?	Previous RCT?	Date of original treatment
	☐	☐	Y N Unsure	Y / N	
	☐	☐	Y N Unsure	Y / N	

Sensitive to: Heat Cold Pressure Percussion Biting/Chewing

Discomfort: Mild Moderate Severe Throbbing Dull ache Sharp Lingering

Meds given: Antibiotic: ______________ **Started** ______________

Analgesic: ______________ **Started** ______________

What is the proposed restorative plan for the tooth? (Please circle)

1. A bonded composite/amalgam restoration
2. A crown
3. No plan has been discussed

After completion of the root canal procedure would you like us to? (Please circle)

1. Leave a post space or
2. Place a bonded post and core
3. Fill coronal pulp chamber with glass ionomer to be used as a base
4. Other: ______________________

Are there any medical conditions we should be aware of?

Is your patient taking any medications? Y N If yes please specify:

Comments: ____

____

____

____

PHONE: 519-673-5293 **FAX:** 519-673-6323 **EMAIL:** INFO@SAVANNADENTAL.CA
ADDRESS: 1135 ADELAIDE ST. NORTH. 3RD FLOOR. SUITE #303. LONDON, ON. N5Y 5K7