



TEXAS ROOT CANAL SPECIALISTS

CADE BRAWLEY, DDS, MS • JEREMY FIKE, DDS, MSD

Date: _____

Dentist: _____

Phone: _____

Tooth #: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Cell Phone: _____

Email: _____

Home Phone: _____

Insurance Carrier: _____

Subscriber Name: _____

Subscriber DOB: _____

Member ID: _____

PATIENT CARE REQUESTS

(Please Circle One)

Consultation RCT Retreatment Apical Surgery

Clinical Findings:

- Asymptomatic
- Pain
- Swelling

Restorative Requests:

- Place Final Restoration
- Place Core Buildup
- Place Temporary Restoration

Additional Notes:

3131 Green Meadow Dr. | San Angelo, TX 76904 | 325.939.2848 (p) | 325.939.2249 (f) | referrals@txrootcanals.com

Please provide bottom portion to the patient. Send top portion by fax to 325.939.2249 or secure upload at <http://referrals.txrootcanals.com>.

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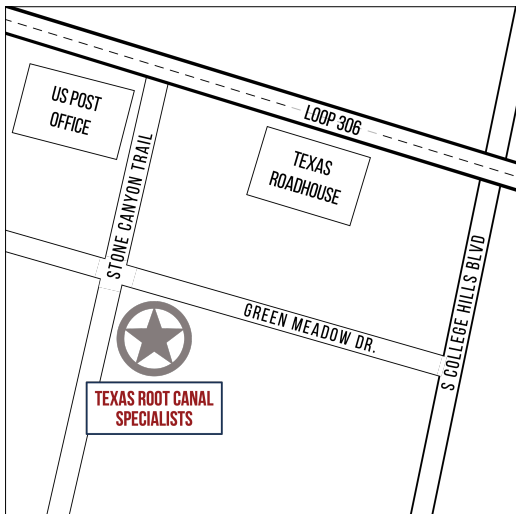


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Appointment:

Date _____

Time _____



PATIENT INSTRUCTIONS

1. If an appointment was not scheduled for you, please call us at 325.939.2848 and we will be happy to assist you.
2. You will receive an email with a link to complete your paperwork online before your appointment. Please complete this promptly so our doctors have plenty of time to prepare for your visit.
3. Please bring a list of your current medications to your visit.
4. A specialized digital image called a CBCT will be taken at our office to aid in the diagnosis and treatment of your tooth.
5. Most of our root canals are done with local anesthesia. You can drive yourself to and from your appointment. You may eat and take all medications as you normally would.
6. If you choose to receive sedation we will require a consultation appointment prior to treatment, at which time you will be given specific instructions.
7. Payment will be required at the time of your appointment.
8. Please contact our office with any specific concerns or questions.

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