Fast Track Appointment Form

Pensacola Endodontics, LLC

Please complete this form in its entirety. Once completed you can simply

Fax to: 850-332-6561 or Email to: Info@pensacolaendo.com

Patient Information

Patient Name:_____ Phone #: _____

Email: _____

Patient Interview

Please circle the tooth number(s) that are marked on your referral form	**UR 1 2 3 4 5 6 7 8 UL 9 10 11 12 13 14 15 16** **LR 32 31 30 29 28 27 26 25 LL 24 23 22 21 20 19 18 17**
Who is your general dentist referring you?	_____
What is reason for your root canal? (Diagnosis)	_____ _____

Has this tooth had a previous root canal?

- ☐ **Yes Approximate date:** _____
- ☐ **No**

Please select any of the following you are currently experiencing.

- ☐ Sensitive to cold
- ☐ Sensitive to hot
- ☐ Swelling
- ☐ Pain when biting
- ☐ Constant pain
- ☐ Intermittent pain
- ☐ Sharp pain
- ☐ Dull pain
- ☐ Throbbing pain
- ☐ I have a permanent crown on this tooth

Do you typically experience dental anxiety?

- ☐ Yes
- ☐ No

Were you prescribed an antibiotic?

- ☐ Yes Antibiotic prescribed_____
- ☐ No

Any additional information you would like to share with us:

_____

_____

Primary Dental Insurance Company_____

Policy Holder_____

Member # _____ Group # _____ Date of Birth: _____

Secondary Dental Insurance Company _____

Policy Holder _____ Date of Birth _____

Member # _____ Group #_____

Please visit our website for new patient forms and practice information at www.pensacolaendo.com.

Thank you for helping us to expedite the scheduling process.