



CENTRAL COAST

Endodontics



SPECIALIST MEMBER

Daniel J. Pierre, DDS, MS, Inc.

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CentralCoastEndodontics.com

referrals@centralcoastendodontics.com

Welcoming _____

Tooth or Area _____

Referring Dr. _____ Date _____

Appointment Day _____ Date _____ Time _____

Preferred Communication Mail Phone E-mail _____

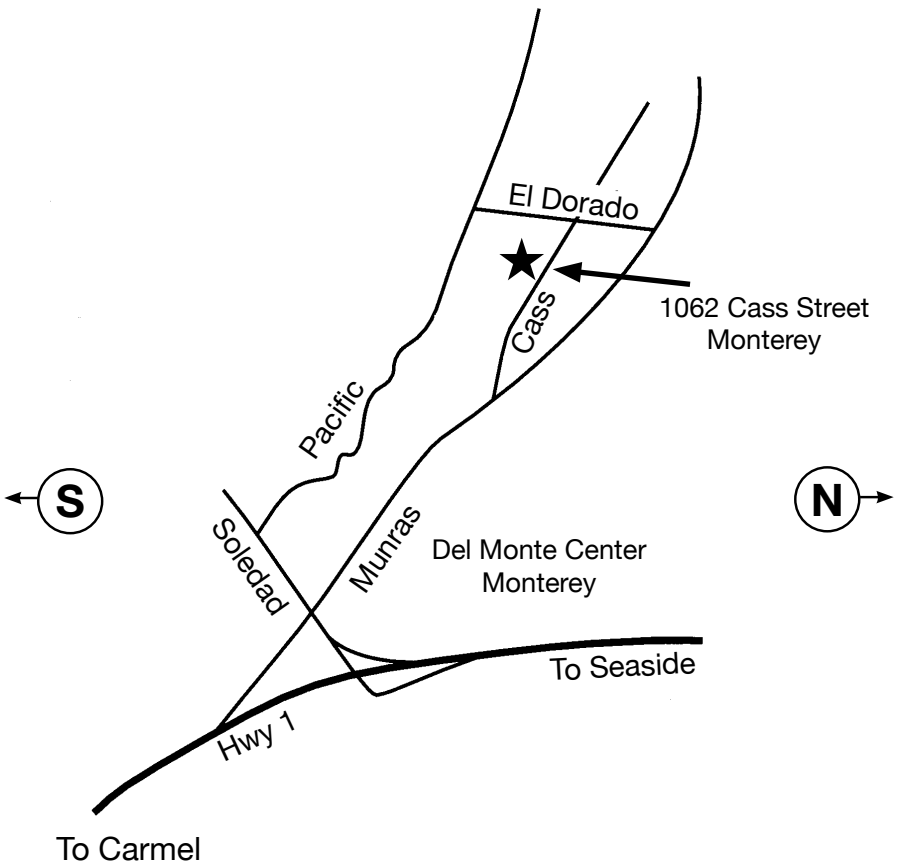
DETAILED HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Trauma | <input type="checkbox"/> Cold/Hot Sensitivity |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Pulp Exposure/Cap | <input type="checkbox"/> Deep Restoration |
| <input type="checkbox"/> Crack/Fracture | <input type="checkbox"/> Prior Root Canal | <input type="checkbox"/> Recent Restoration |
| Rx Prescribed | <input type="checkbox"/> Antibiotics _____ | <input type="checkbox"/> Analgesic |

TREATMENT IN ENDODONTIC OFFICE

- Diagnose and Treat As Necessary
- Non Surgical Root Canal Treatment
- Non Surgical Root Canal Retreatment
- Surgical Root Canal Treatment
- Provide Post Space
- Provide Core
- Provide Post and Core

Comments/Special Requests _____



Please Bring:

- ~ This slip to your appointment.
- ~ Insurance information, payment method, and forms.
- ~ A parent or legal guardian if you are a minor (18).

Payment Policy:

Contracted insurance patients are responsible for their estimated portion at time of service. Uncontracted insurance patients are responsible for all treatment fees at time of service and will receive prompt, professional assistance filing their claims. We are committed to our treatment fees not preventing our patients from carrying out endodontic treatment. Please call us to discuss any questions or concerns 831-373-2128.