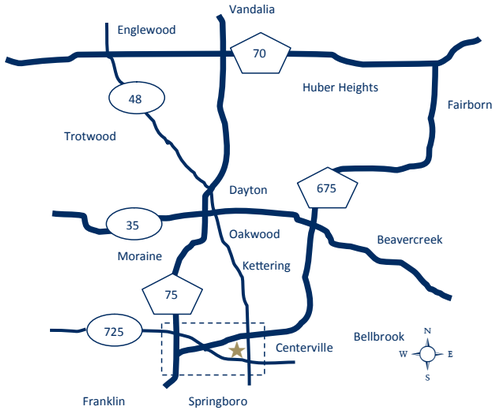

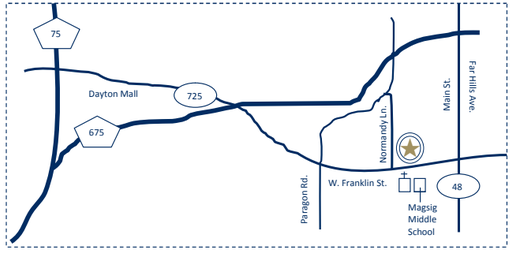

Gallatin G
ENDODONTICS

Appointment

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri

Date: _____

Time: _____

Eric Gallatin, DDS, MS

221 W. Franklin Street, Centerville, OH 45459

Tel 937-610-0707 • Fax 937-610-0699

Today's Date _____

Patient's Name _____

Referring Doctor _____

Please circle the tooth or area in question:

UPPER RIGHT								UPPER LEFT							
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
LOWER RIGHT								LOWER LEFT							

☐ **EVALUATION** is needed due to vague symptoms and/or restorability of tooth is in question

☐ **(RE-) TREATMENT** is needed due to symptoms and/or to properly restore the tooth

☐ **PULP EXPOSURE** occurred

☐ **POST SPACE** needed - please prepare

Tooth pain is felt with:

- ☐ Cold
- ☐ Hot
- ☐ Percussion
- ☐ Biting

Area Exhibits:

- ☐ Oral/Facial Swelling
- ☐ Tenderness
- ☐ Fistula

Remarks: _____

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