D. WAYNE HUGHART, DDS, MS PRACTICE LIMITED TO ENDODONTICS

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Patient's Name:	
Appointment Date:	
Referred by Dr.:	
Office Number:	
Office Number.	
Tooth #(s) / Area to be examined:	
Postorativo Plan	
Restorative Plan:	
 □ Endodontics necessary for restoration □ Retreatment □ Post Removal □ Tooth opened for drainage □ X-ray revealed pulpal involvement □ X-ray revealed radiolucency 	□ Vague tooth discomfort, evaluate □ Pain, sensitivity or swelling, evaluate □ Post space preparation □ Pre-medication necessary □ Other
Remarks:	

