815 College Blvd, Suite 106 Oceanside, CA 92057
Phone: 760-906-4466 | Fax: 760-239-0105
email: info@wecare.dental
www.wecare.dental

Please circle: **OS ENDO**

Patient Name & DOB: _____ Phone number: _____

Insurance: _____ Home Address: _____

Subscriber ID/SS#: _____ Sub Name & DOB: _____

Medical Alerts: _____ Additional Notes: _____

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

For OS:

- ☐ Surgical Removal of Erupted Th # _____
- ☐ Wisdom Tooth Removal Th # _____
- ☐ Alveoplasty _____
- ☐ Implant Th # _____
- ☐ Other / Comments _____
  _____

For ENDO:

- ☐ Tooth has been opened and left open.
- ☐ Tooth has been opened, medicated, and sealed.
- ☐ I have placed the patient on Antibiotic: _____
  And/or Analgesic: _____
- ☐ Leave post space.
- ☐ Patient has a toothache, please evaluate and treat as needed.
- ☐ Evaluate for Retreatment.
- ☐ Other / Comments: _____
  _____

Referring Office: _____ **Date:** _____

Referring Dentist: _____ **Office Phone #:** _____