

Palo Alto Endodontic Center

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Tel 650-485-2514

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Date _____

Tooth# / Area: _____

Introducing _____

Referred by Dr. _____ Phone# _____

Please Call: Before After patient consultation

Diagnostic quality radiographs Attached Email

Candidate for sedation
(patient will require initial consult prior to treatment)

Recent Dental History

- Pulp exposure
- Tooth has been opened, medicated and sealed
- Patient has been placed on antibiotics / analgesics
- Recent restoration Type _____ Date _____
- Other comments _____

Treatments Requested

- Consultation Only
- Evaluate and treat as indicated
- Evaluate for:
 - Restorability
 - Retreatment
 - Apicoectomy
 - Resorption
 - Internal bleaching
 - Other _____

After Completion of treatment

- Temporize with sponge and caviti
- Provide Post Space
- Provide build-up Alloy Comp GI
- Provide post and build-up Alloy Comp GI

Appointment Date _____ Time _____

This time is reserved exclusively for you. If you are unable to keep your appointment, 24 hours notice is appreciated. Thank you

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