Mission Bay View Endodontics
A. JAYSON TENGONCIANG, D.M.D., Inc
missionbayviewendodontics@gmail.com
www.missionbayviewendodontics.com
3737 MORAGA AVE., B313
SAN DIEGO, CA 92117
PHONE (858) 270-2760
FAX (858) 270-2871

APPT DATE:

_____

Day Time

Introducing_____

Patient will return to referring dentist for final restoration.

Pt. Phone (_____) _____

Referred by Dr._____Date:_____

R L

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

- o Please evaluate and treat as needed
- o Please evaluate/treat for retreatment
- o Please evaluate/treat for apicoectomy
- o Endodontics necessary for proper restoration
- o Consultation only

Other: _____

_____

_____

SYMPTOMS

- o Patient is Asymptomatic
- o Hot and/or Cold Sensitivity
- o Discomfort Upon Palpation
- o Discomfort Upon Percussion/Chewing
- o Swelling or Fistula
- o Periapical Radiolucency
- o Separated Instrument
- o Pulp Exposure

RESTORATIVE REQUEST

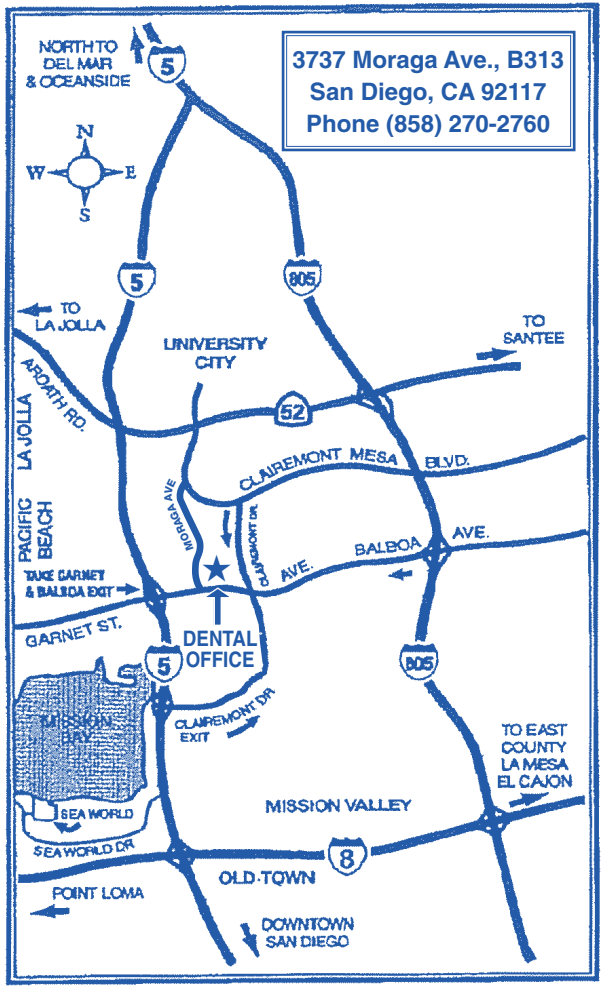
- o Post Space
- o Post and Core
- o Remove Crown
- o Build Up For Final Restoration
- o Place Final Access Restoration

Other:_____

Please send copy of PA and referral to our office

Note: Map to our office and pre-appointment instructions on back

White Copy - Patient Yellow Copy - Referring Doctor



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PRE-APPOINTMENT INSTRUCTIONS FOR PATIENT:

1. New Patient forms can be downloaded and printed from our website, www.missionbayviewendodontics.com. Please bring the completed forms with you to your appointment.
2. Avoid any pain medication 8 hours prior to your visit.
3. Please be prepared to pay your appropriate treatment fee, in full, the day of your appointment.
4. We require at least 24-hours' notice if change of appointment is *absolutely* necessary.
5. All patients will need to provide a valid photo ID and an insurance card (if applicable).

If you have any questions regarding your appointment, do not hesitate to call or email the office. We look forward to seeing you!