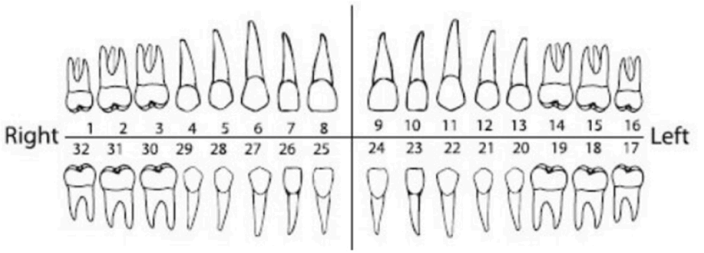
River City
ENDODONTICS

Matthew J. Walker, DDS, MSD
113 Church Street • O'Fallon, MO 63366
pm@rivercityendo.com • www.rivercityendo.com • (636)362-4040

Patient Name_____ **Referred By**_____



Dental History:

☐ Symptoms_____ ☐ Endodontic Treatment Initiated ☐ Trauma

☐ Previous Root Canal Therapy ☐ Pulp Exposure ☐ Periapical Radiolucency

Treatment Request:

☐ Consultation Only ☐ Treatment

Post-Operative Instruction:

☐ Prepare Post Space ☐ Core Buildup / Restore Access with Composite

Comments:_____

Instructions for Patients:

1. Please bring this referral with you to your appointment.
2. Please bring all dental insurance information.
3. Please bring a current list of all medications.
4. Please inform office if antibiotic premedication is required prior to treatment.