



Dr. Christine L. Ogden, DMD
Dr. Ross Rosenblatt, DMD

Today's Date _____

Patient's Name _____

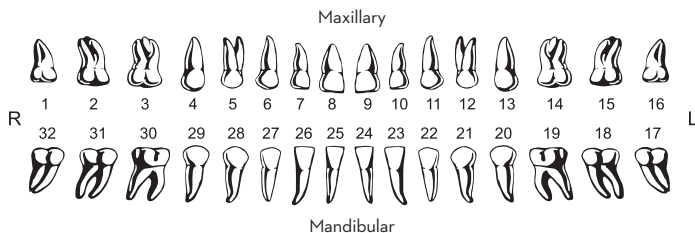
Appointment Date _____ Time _____ am/pm

Referred by Dr. _____

Referring Dr.'s E-Mail _____

- | | |
|---|---|
| <input type="checkbox"/> Evaluation only | <input type="checkbox"/> Possible apical surgery or retreatment |
| <input type="checkbox"/> Root canal therapy | <input type="checkbox"/> Please leave post space |
| <input type="checkbox"/> CBCT 3D imaging | <input type="checkbox"/> Restore access with composite |

Please circle tooth to be treated



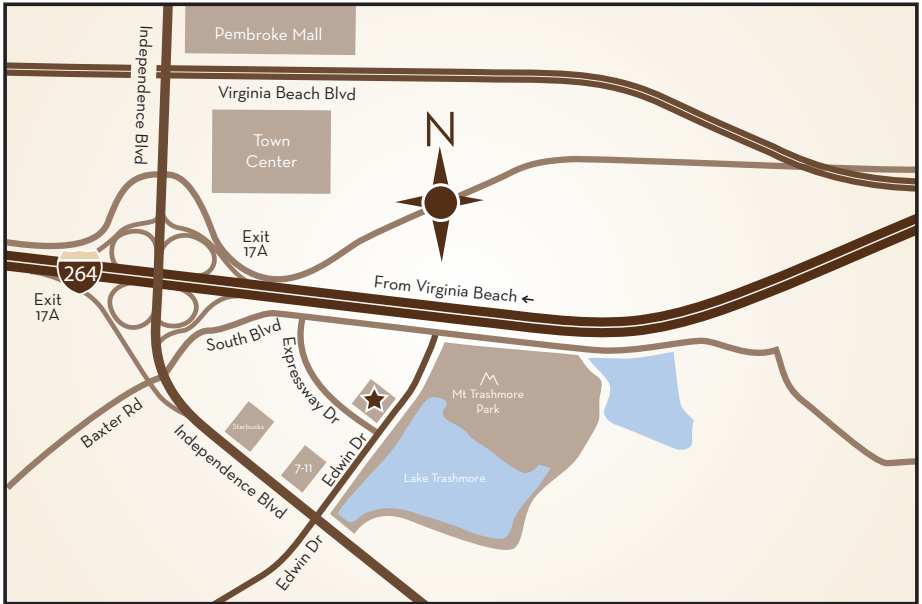
Referred Due To:

- Pain
- Radiographic findings
- Carious pulp exposure
- Swelling
- Oral conscious sedation
- Other endodontic management
*(trauma, vital pulp therapy, resorption
difficult anesthesia, calcification, difficult access)*

Status of Tooth:

- Previous completed root canal
- Root canal started but not finished
- Previous post
- Crown permanently cemented
- Crown temporarily cemented

Remarks _____



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IF YOU HAVE DENTAL INSURANCE

As a courtesy to you, we will file all insurance claims on your behalf with the information provided to us at the time of scheduling your initial appointment. We will notify you 1-2 weeks prior to your scheduled appointment of any co-pays that will be due IN FULL at the time of your appointment. We have found that some insurance companies do not cover all dental services and any co-pays we review with you prior to or during your appointment are an ESTIMATE. Upon receipt of payment from your insurance company, we will bill you for any outstanding balance or refund any overpayment directly to you.

Patients 18 years of age or under must have a parent or guardian present to give written consent for treatment.

If you are unable to keep your appointment, please give us the courtesy of 24 hours notice; a charge may apply otherwise. Thank you for your consideration.



www.virginiabeachendo.com
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