

Linda Ricks, DDS, MS, PC Endodontics



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Date: _____

Patient: _____

Address: _____

Send or email X-rays to **info@lindaricks.com**

Phone (H): _____ (W) _____

☐ Please call pt. ☐ Pt. will call you

Appointment _____

Day								Date								Time							
Please Circle Teeth to be Treated																							
Right																Left							
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16								
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17								

post space? ☐ Yes ☐ No

Is the patient in pain? none slight moderate severe

Is there swelling? none slight moderate severe

Evaluate for:

- periapical surgery
- apexification
- trauma
- luxation / avulsion / fracture

Please call me: ☐ Before examination ☐ After examination

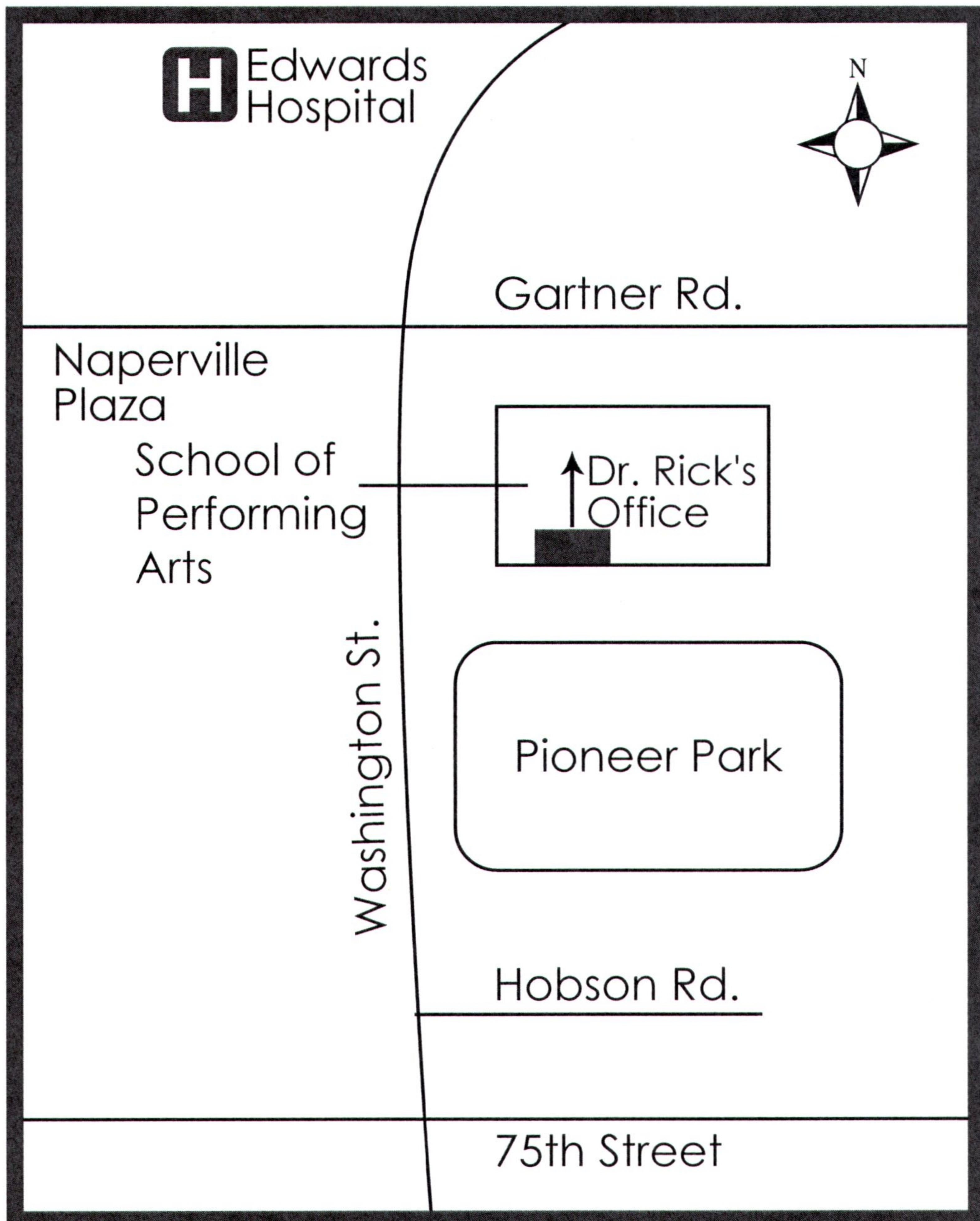
Preferred telephone # _____

Comments:

Dr. _____

Directions to Our Office

1112 South Washington • Suite 217
Naperville, IL 60540



*Please call our office at 630-579-0970
if you need any further assistance*