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Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Location: \_\_\_\_\_

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Having Pain:  YES  NO

ANTIBIOTIC PRESCRIBED \_\_\_\_\_  ANALGESIC PRESCRIBED \_\_\_\_\_

APPT DATE / TIME: \_\_\_\_\_

<p><b>Service Requesting</b></p> <p><input type="checkbox"/> CONSULT ONLY</p> <p><input type="checkbox"/> RCT / TREAT AS NEEDED</p> <p><input type="checkbox"/> RETX / TREAT AS NEEDED</p> <p><input type="checkbox"/> APICO</p> <p><input type="checkbox"/> LEAVE POST SPACE</p> <p><input type="checkbox"/> TEMP FILLING</p> <p><input type="checkbox"/> PERM FILLING</p> <p><input type="checkbox"/> OTHER _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Please see map on back.

