



Rancho Mirage  
Palm Springs  
ENDODONTICS

Practice Limited to Microscopic Endodontics  
**Eddie Halasa, D.D.S., M.S.D**  
Diplomate of the Board of Endodontics

**Rita J. Hung, D.M.D., M.P.H., M.S.D.**  
Board Eligible

71780 San Jacinto Drive, B3 Rancho Mirage, CA 92270

Office: 760.779.0350 Fax: 760.779.0348

Email: [staff@ranchomirageendodontics.com](mailto:staff@ranchomirageendodontics.com)

558 S. Paseo Dorotea, Suite 9, Palm Springs, CA 92264

Office: 760.318.0101 Fax: 760.318.0404

Email: [staff@palmsspringsendodontics.com](mailto:staff@palmsspringsendodontics.com)

Check box if referred to RME

Check box if referred to PSE

Today's Date: \_\_\_\_\_

This time is reserved for you. If by necessity you must cancel your appointment please notify us at least one day in advance

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Day: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Insurance: \_\_\_\_\_

You have been referred for specialized care to an endodontist. Our office will make every effort to make your visit with us a comfortable experience. Please assist us by providing the following information prior to your appointment.

- Your referral slip & X-rays if applicable
- A list of prescribed medications you are presently taking
- If you have dental insurance, bring a copy of the card (this will save time and allow us to help you process any claims)
- Please do not take any pain medications 6 hours before your appointment

**IMPORTANT: All Patients under 18 years of age must be accompanied by a parent or guardian at the consultation visit**

Please circle tooth or teeth for endodontic consideration: 

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

- |   |   |
|---|---|
| <input type="checkbox"/> Consultation & Diagnosis                         | <input type="checkbox"/> Evaluation for retreatment                   |
| <input type="checkbox"/> Pulp was exposed (vital / non-vital)             | <input type="checkbox"/> Endodontics necessary for proper restoration |
| <input type="checkbox"/> Radiolucency and/or pulpal involvement noted     | <input type="checkbox"/> Final restoration                            |
| <input type="checkbox"/> Patient has (had) pain / swelling or sensitivity | <input type="checkbox"/> Prepare post space                           |
| <input type="checkbox"/> Please evaluate & treat as necessary             | <input type="checkbox"/> Place post & build-up                        |

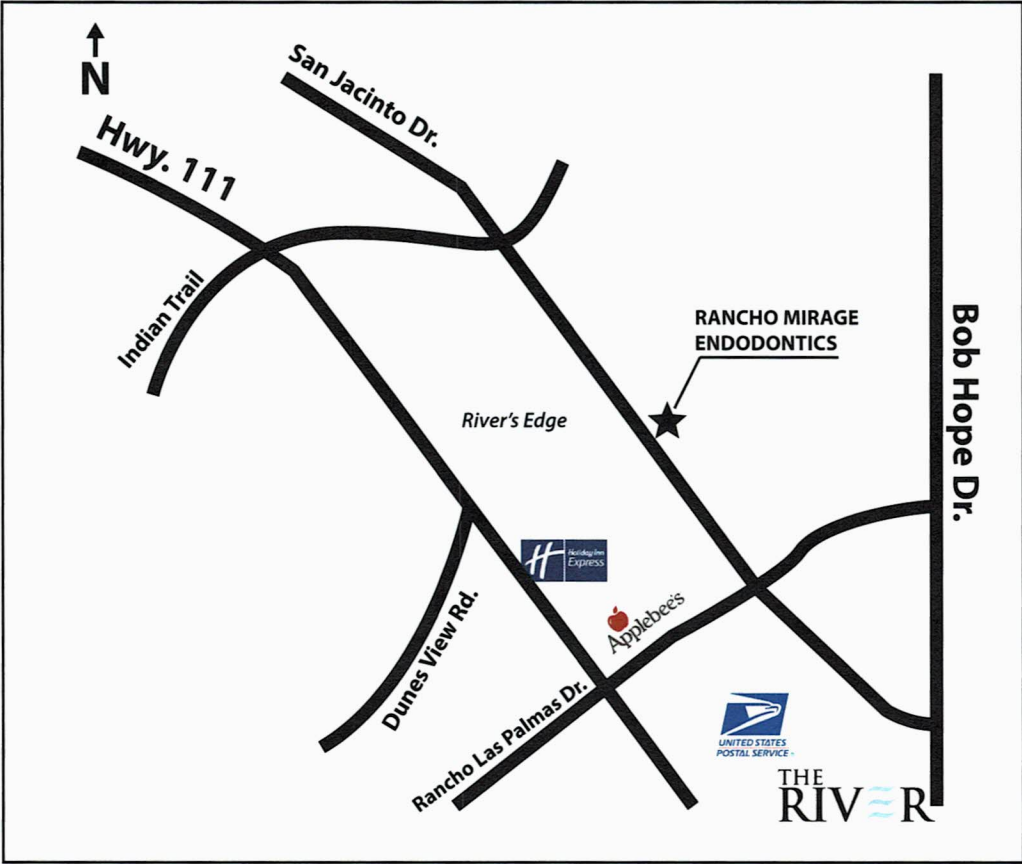
Other findings or remarks \_\_\_\_\_

Analgesic prescribed \_\_\_\_\_  Antibiotic prescribed \_\_\_\_\_

Patient will be returned to referring doctor for final restoration

For more info about our practices please log on to our website at:  
[www.RanchoMirageEndodontics.com](http://www.RanchoMirageEndodontics.com) or [www.PalmSpringsEndo.com](http://www.PalmSpringsEndo.com)

RANCHO MIRAGE, CA



PALM SPRINGS, CA

