

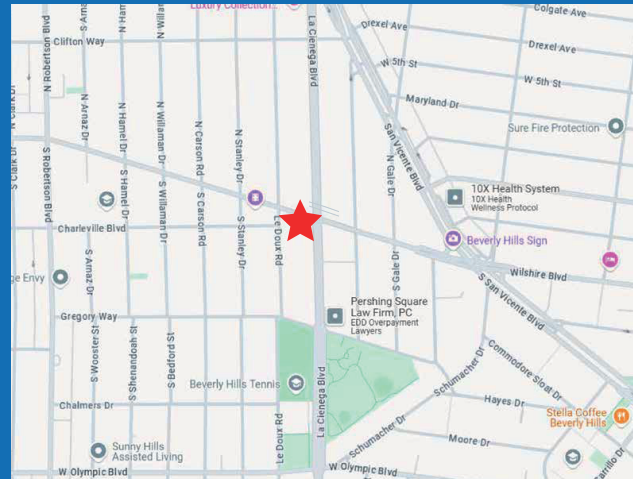


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ENDODONTICS

PATIENT'S NAME		REFERRING DOCTOR	TODAY'S DATE	APPT. DATE	APPT. TIME	
TOOTH #	COMMENTS					

Please bring this slip, medical information, insurance, & x-rays to your appointment — or have them emailed/messaged prior to your arrival.

TREATMENT REQUESTED	<input type="checkbox"/> CONSULTATION
	<input type="checkbox"/> ROOT CANAL TREATMENT
	<input type="checkbox"/> RETREATMENT
	<input type="checkbox"/> APICOECTOMY
	<input type="checkbox"/> INTERNAL BLEACHING
	<input type="checkbox"/> CBCT OF THE FOLLOWING AREA:

POST-OP CARE	<input type="checkbox"/> SPONGE & CAVIT
	<input type="checkbox"/> CORE BUILD-UP (COMPOSITE)
	<input type="checkbox"/> POST SPACE PREPARATION
	<input type="checkbox"/> POST & CORE BUILD-UP
	OTHER: _____