MICRO ENDODONTICS CENTER

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Practice Limited to Endodontics

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Introducing:_____ Phone :_____

Referred by Dr._____Office Phone:_____

Appointment Date: _____ Time:_____

Tooth #_____

Please Circle Tooth (or Teeth) To Be Evaluated:

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

Reason For Referral:

____Consultation Only
____Root Canal Therapy
____Retreatment
____Apicoectomy/Retrofill
____Apexification
____Place Core Build Up Only
____Place Core Build Up & Post
____Prepare Post Space Only
____Bleach: Vital/Non-Vital
____Please Call Prior To Treatment
____Other_____
_____

Remarks:

_____
_____
_____

Please Bring This Card with You, Thank You