PRECISION ENDODONTICS

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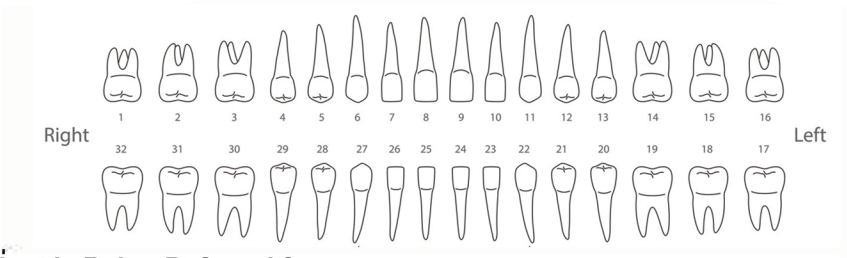
Patient Name_____ Date_____
Email_____ Phone_____
Referring Doctor_____
Doctor Phone Number_____

Please Mark Teeth to be Evaluated or Treated



Patient is Being Referred for

____Consultation and Treatment as Indicated
____Consultation Only

____Root Canal Therapy
____Retreatment
____Periapical Surgery (Apicoectomy)
____Internal Bleaching
____Suspicion of Root Fracture
____Traumatic Injury

Please Restore Access Cavity With

____Temporary
____Core Buildup
___Please Leave Post Space

Comments _____
_____
_____
_____
_____

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