

Date _____

Patient _____

Referred by Dr. _____

Please mark tooth/teeth to be treated

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

ENDODONTIC CONSIDERATIONS:

- Patient has pain to:
 - cold heat pressure swelling
- Tooth has been previously opened
- X-ray revealed radiolucency
- Previous root canal Other

TREATMENT REQUESTED:

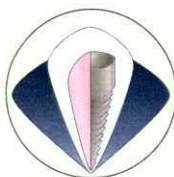
- Diagnosis only Treatment
- Prepare post space Permanent restoration

DENTAL IMPLANT CONSULTATION:

- Evaluation only Treatment

Remarks _____

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ENDODONTIC CENTER

Preserving smiles with innovative care
ROOT CANALS - IMPLANTS

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