PRECISION ENDODONTICS

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Date _____

PATIENT

Name _____ D.O.B. _____

Email _____ Phone _____

INSURANCE

Subscriber Name _____ D.O.B. _____

Company _____ Member ID _____ Group ID _____

PLEASE CIRCLE TEETH TO BE EVALUATED/TREATED

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

- ☐ Endodontic Consultation
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Endodontic Microsurgery
- ☐ Cone-Beam C.T.
- ☐ Other _____

RESTORATIVE INSTRUCTIONS

- ☐ Restore Access Opening
- ☐ Place Temporary Restoration
- ☐ Place Post/Build-up as Needed
- ☐ Prepare Post Space
- ☐ Please Call Our Office

Referred by Dr. _____ Phone _____

Remarks

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Email: office@precisionendodallas.com | Phone: 972.612.1668 | Fax: 972.612.1688