



East County

ENDODONTICS

Practice Limited to Endodontics

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Date _____

Referred by _____

Patient _____

Tooth # _____

Right

1 2 3 4 5 6 7 8
32 31 30 29 28 27 26 25

Left

9 10 11 12 13 14 15 16
24 23 22 21 20 19 18 17

- Consultation / Diagnosis
- Endodontic Treatment
- Endodontic Retreatment
- Other _____

- Request CBCT
- Request Post
- Apical Surgery
- Internal Bleach

Crown to be remade Yes No

Comments _____

Medication Prescribed _____



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Please bring this referral as well as your insurance information to your appointment.
Please give 24 hour notice in case of cancellation. Please arrive 15 mins early to fill out paperwork.

