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Appointment Date: ______________________________

PLEASE DO NOT TAKE ANY PAIN MEDICATION
DAY OF APPOINTMENT

Introducing ______________________________

Referring Doctor ______________________________

Referring Doctor's Phone Number ______________________________

TOOTH #	

RIGHT LEFT

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

Please Evaluate

Patient is Having Pain

Endodontics Necessary for Restoration

Vital pulp Exposure

Tooth Has Been Opened for RCT
on

Prior Endodontic Treatment

Place Core Buildup

Place Post

Temporize Only

Prepare Post Space

Crown Will Not Be Replaced

Crown Will Be Replaced

Apical Surgery

Please Send
More Referral Slips

Date of Referral: ______________________________

SEND