ANDREWS ENDODONTICS

Date: _____

Patient: _____

Referred by: _____

Appointment

Date: _____

Time: _____ AM/PM

Kindly give 24-hour notice when changing an appt

PLEASE MARK AREA IN QUESTION

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

ENDODONTIC TREATMENT DESIRED

☐ Consultation Only ☐ Root Canal Treatment ☐ Root Canal Retreatment ☐ Apical Surgery

RESTORATIVE TREATMENT DESIRED

☐ Place Sponge/Temp Restoration ☐ Leave Post Space ☐ Place Post ☐ Core Build-up (Amalgam or Resin)

COMMENTS

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