DAVISVILLE
ENDODONTICS

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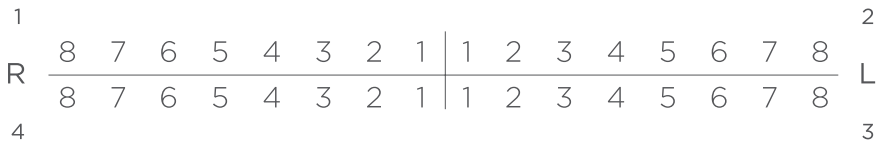
Introducing:

Given Name: _____ Family Name: _____

Appointment Date: ____ ____ _____ Day: S M T W T F S Time: _____ : _____



Patient has been referred for:

- ☐ Non-surgical root canal therapy
- ☐ Surgical root canal therapy
- ☐ Retreatment of previous root canal therapy
- ☐ Emergency treatment will be rendered

I have prescribed the following medications:

- ☐ Antibiotic
- ☐ Analgesic
- ☐ Anti-inflammatory

Patient may be interested in sedation:

- ☐ Yes

Crown/Bridge is cemented:

- ☐ Temporary ☐ Permanently

Filling Required:

- ☐ Temporary ☐ Permanent

Need for full coverage discussed:

- ☐ Yes ☐ No

Post space required:

- ☐ Yes ☐ No

Radiographs:

- ☐ Enclosed ☐ Previously sent

Reason for Appointment:

_____

_____

_____

_____

Referred By: _____ Referral Date: ____ ____ _____

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