everett endodontics

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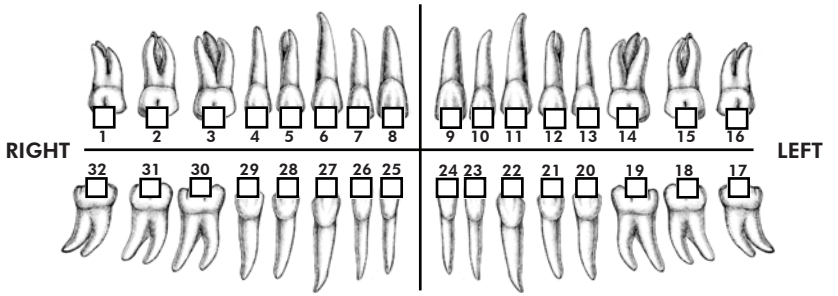
Date .....

Patient's Name .....

Home Phone ..... Work Phone .....

Cell Phone ..... E-mail .....

Referring Dentist (name) .....




Date/Time of appointment .....

☐ Evaluation only .....

☐ Root Canal Treatment .....

☐ Re-Tx ☐ Surgical Tx

☐ Restoration if possible ☐ Temporary only

☐ Post Space Preparation ☐ Bleach

Treatment plan includes .....

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Other information .....

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