BALDASSANO ENDODONTICS

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Practice Limited to Endodontics

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Patient _____ Date _____

- ☐ Consultation - Microscopic Evaluation
- ☐ CBCT Evaluation
- ☐ Root Canal Therapy
- ☐ Retreatment Therapy

Post Room ☐ yes ☐ no

- ☐ Apicoectomy/Microsurgery
- ☐ Root Amputation/Hemisection
- ☐ Regenerative Endodontics/Root-end Closure

| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

Referred by Dr. _____ Tel. No. _____

Comments: _____

– PLEASE BRING THIS FORM TO YOUR APPOINTMENT –

**Map on Reverse**