



Connecticut Endodontics

Microsurgical Root Canal Specialists

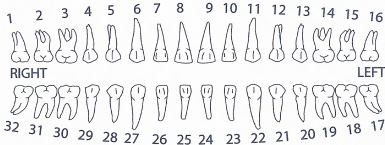
Rick Morant, DMD, MS

Patient name: _____

Referred by Dr.: _____

Appointment date/time: _____

Please evaluate/treat the following teeth:



- ☐ Patient has pain, swelling or sensitivity.
- ☐ Endodontic therapy is necessary for proper restoration.
- ☐ Please evaluate for periapical or corrective surgery.
- ☐ Post space needed?

Comments: _____

(directions and map on reverse)

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ctendo.com