CarePoint
ENDODONTICS

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Date of Referral : _____
Date & Time of Appointment: _____
Patient's Name: _____
Patient's Contact Number: _____

Referring Doctor Name: _____
Name of Practice: _____
Office Contact Number: _____

Tooth or Teeth #: _____

Procedure:

- ❑ Evaluation
- ❑ Nonsurgical Root Canal Treatment
- ❑ Retreatment
- ❑ Apicoectomy
- ❑ CBCT
- ❑ IV Sedation

Restoration:

- ❑ Temporary Filling
- ❑ Post Space & Temporary
- ❑ Permanent Core
  - ❑ Composite
  - ❑ Amalgam
- ❑ Permanent Post & Core

Comments:

_____
_____
_____
_____

Please bring this form & any other documents from your dentist to your appointment.

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