Elliot D Haybarger, DMD
233 E. Blackstock Road STE D
Spartanburg, SC 29301
P: 864-576-3678
F: 864-576-3181
www.carepointendodontics.com
info@carepointendodontics.com

Date_____

Referring Doctor's Name_____

Patient's Name_____

Patient's 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

Other_____

Comments_____

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