Auburn Valley Endodontics
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Date _____

Patient Name _____

Ph #_____ Alt Ph # _____

Referred by Dr. _____

Appt. Date _____ Time _____

Tooth /Teeth #s_____

☐ Examination and Root Canal Treatment

☐ Restoration if possible ☐ Temporary only

☐ Post Space Requested

☐ Consultation and Diagnosis

☐ Retreatment

☐ Apicoectomy

Comments_____

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To Our New Patient

Please see reverse side for important information and directions