CITY CENTRE
ENDODONTICS

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Patient Name: _____

☎ _____ ✉ _____

Referred by _____ Date _____

Tooth # / Area of concern:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ Consult ☐ Consult and treatment ☐ Call to discuss ☐ Pre-Implant CBCT

Restoration Requirements

☐ Temporary filling ☐ Permanent filling ☐ Leave Post Space

Comments:

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