



MEDEMA ENDODONTICS

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Please visit our website for patient information and registration forms



THIS WILL INTRODUCE: _____
PATIENT'S PHONE #: _____
APPOINTMENT DATE: _____
TIME: _____

- CONSULTATION IS REQUIRED PRIOR TO TREATMENT
- CONSULTATION WILL OCCUR ON A SEPARATE DAY PRIOR TO APICOS OR RE-TREATMENT UNLESS OTHERWISE REQUESTED BY THE REFERRING DENTIST

PLEASE CHECK ALL THAT APPLY

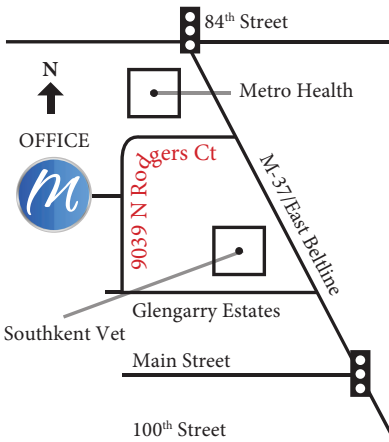
- | | |
|---|--|
| <input type="checkbox"/> Root canal therapy | <input type="checkbox"/> CBCT Evaluation |
| <input type="checkbox"/> Re-treatment | <input type="checkbox"/> Post Space Requested |
| <input type="checkbox"/> Apico | <input type="checkbox"/> Final Restoration Requested |
| <input type="checkbox"/> Consultation Only | |

UPPER

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	
R	_____																	L
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

LOWER

COMMENTS: _____



REFERRED BY: _____

PHONE: _____

DATE: _____

- Other than CBCT, all x-rays are included in the consultation fee
- Payment is required at the time of service
- Patient should provide insurance information prior to their appointment
- Patient will be returning to referring dentist for final restoration unless otherwise indicated above