May River
Endodontics LLC

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Today's Date _____

Patient's Name _____

Patient's Phone _____

Referred by Dr. _____

Dr.'s Phone _____

Dr.'s Email _____

PLEASE MARK TEETH TO BE TREATED

UPPER

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

LOWER

TREATMENT DESIRED

☐ Root Canal Treatment ☐ Root Canal Retreatment ☐ Apicoectomy Surgery

☐ CBCT & Consultation ☐ Consultation Only ☐ Other

_____

_____

RESTORATIVE INSTRUCTIONS

☐ Place Sponge and Cavit ☐ Leave post space

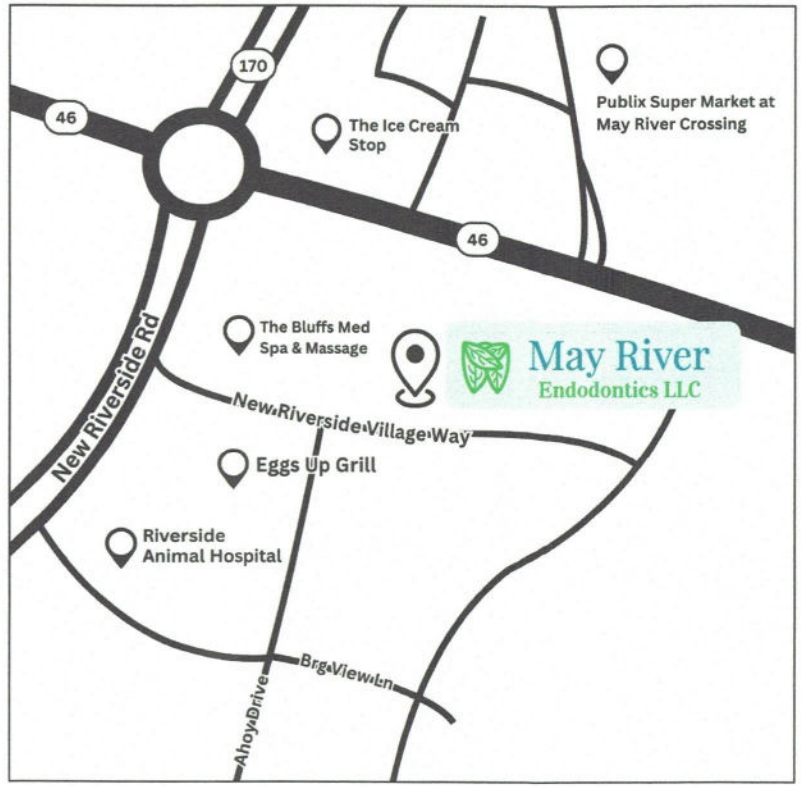
☐ Place core build-up ☐ Place post and build-up

☐ Special Instructions _____

_____

_____

LOCATION



INFORMATION FOR PATIENTS

PLEASE BRING TO YOUR APPOINTMENT:

- This form
- Information to complete a health history
- Name and dose of all current medications
- Dental insurance information

Our staff is happy to help you with any questions.
We look forward to your visit with us.