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- _____ Consult
- _____ Treatment
- _____ Apicoectomy
- _____ CBCT

Patient Name _____

Appointment Date _____ Time _____

Referred by _____

Tooth Number _____

Previous Root Canal Yes / No

- ☐ Seal with a temporary restoration
- ☐ Leave a post space
- ☐ Place a permanent restoration
- ☐ Place a post and permanent restoration
- ☐ Please call me before treatment

Comments: _____

