Carson Endodontics
Root Canal Specialists

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Phone: (757) 942-8737 Fax: (757) 974-8710

Date _____ Patient Phone # _____

Patient Name _____

Referred by Dr. _____

Patient is being referred for the following:

☐ Evaluation/Consult ☐ Root Canal Therapy ☐ Retreatment

For Tooth(s) #: _____

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

When treatment is complete, please:

☐ Restore access opening as needed ☐ Temporary Restoration (Type)_____

☐ Prepare post space ☐ Call concerning patient

Please Email/Fax the Referral & Current Periapical Radiograph

Comments/Special Instructions

_____

_____

_____

Appointment Day: _____ Date: _____ Time: _____

If you are unable to keep this appointment, kindly give 24 hour notice.

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Our Practice Location

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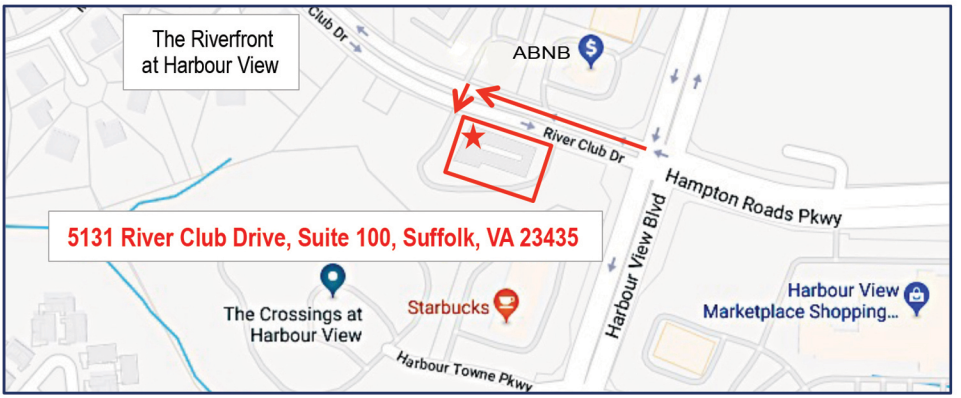

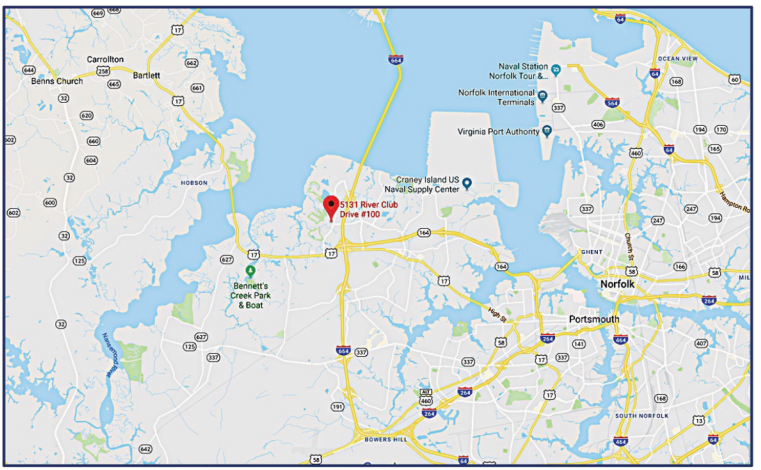

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