

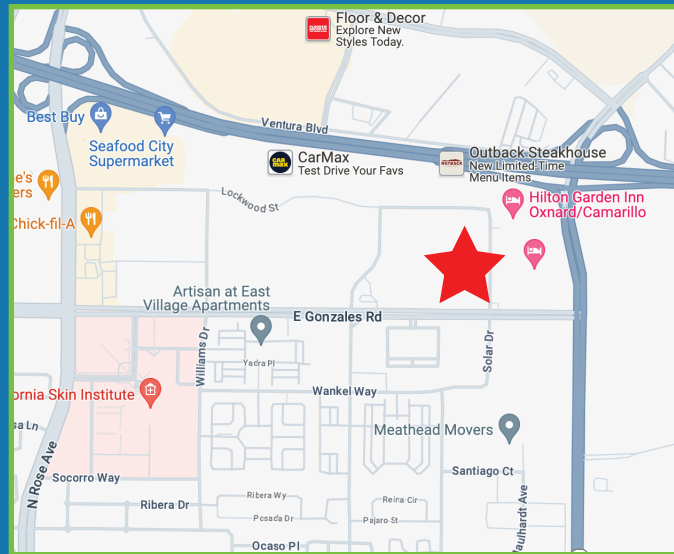


P: (805) 853-3636 **F:** (805) 609-3020

E: SolarEndodontics@gmail.com

W: www.SolarEndodontics.com

A: 1901 Solar Dr., Suite 250, Oxnard, CA 93036



ENDODONTICS

PATIENT'S NAME		REFERRING DOCTOR	TODAY'S DATE	APPT. DATE	APPT. TIME	
TOOTH #	COMMENTS					

Please bring this slip, medical information, insurance & x-rays to your appointment – or have x-ray's e-mailed prior to your arrival.

TREATMENT REQUESTED	<input type="checkbox"/> CONSULTATION	POST-OP CARE	<input type="checkbox"/> SPONGE & CAVIT
	<input type="checkbox"/> ROOT CANAL TREATMENT		<input type="checkbox"/> CORE BUILD-UP (COMPOSITE)
	<input type="checkbox"/> RETREATMENT		<input type="checkbox"/> POST SPACE PREPARATION
	<input type="checkbox"/> APICOECTOMY		<input type="checkbox"/> POST & CORE BUILD-UP
	<input type="checkbox"/> INTERNAL BLEACHING		OTHER: _____
	<input type="checkbox"/> CBCT OF THE FOLLOWING AREA: _____		