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324 W Superior St, Suite 824, Duluth MN 55802

Date ______________________________

Patient Name ______________________________

Phone ______________________________

For:

- ❑ Consultation
- ❑ RCT
- ❑ Apexification
- ❑ Retreat
- ❑ Apical Surgery
- ❑ Hemisection
- ❑ Root Amputation
- ❑ Replantation
- ❑ Bleaching

Medical & Treatment History: ______________________________

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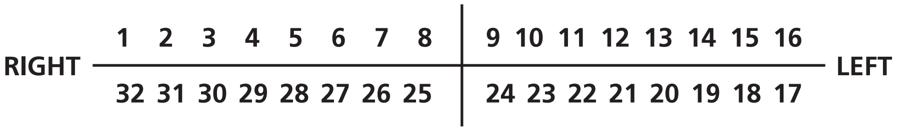

Appointment Date ______________ Time ______________

Referring Doctor ______________________________

Referring Practice ______________________________

Email ______________________________

Phone ______________________________

Fax ______________________________