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2717 Superior Drive Northwest, Suite B, Rochester, MN 55901

Date _____

Patient Name _____

Phone _____

For: ☐ Consultation
☐ RCT
☐ Apexification
☐ Retreat
☐ Apical Surgery

☐ Hemisection
☐ Root Amputation
☐ Replantation
☐ Bleaching

Medical & Treatment History: _____

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

Appointment Date _____ Time _____

Referring Doctor _____

Referring Practice _____

Email _____

Phone _____

Fax _____

