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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	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	LEFT

Appointment Date _____ Time _____

Referring Doctor _____

Referring Practice _____

Email _____

Phone _____

Fax _____

