Advanced Endodontic Associates

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REFERRAL INFORMATION

Patient:_____

Appointment:_____ _____ _____
Day Date Time

Tooth/Area:_____

Remarks:_____

_____

_____

☐ Call before exam ☐ Call after exam

Radiograph(s): ☐ Emailed ☐ Provided ☐ Take

Crown/bridge cemented with: ☐ Permanent Cement ☐ Temporary Cement

☐ Perform post space ☐ Place definitive core restoration

☐ CBCT and Evaluation

_____ Dr._____
Date

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