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Parkway Endodontics

Practice Limited to Endodontics
www.parkwayendodontics.com

Date: ________________

Referring Doctor: ______________________________

Introducing:__________________________ Tooth: _________

Symptoms:

________ Cold
________ Percussion
________ Palpation
________ Swelling
________ Hot
________ Bite
________ Fistula

Treatment:

________ Consult
________ Consult/Root canal treatment
________ Consult/Conventional Retreatment
________ Consult/Apicoectomy treatment

Post Space: ________ Yes ________ No

Other notes: ____
____
____
____

Please email patient radiographs to office@parkwayendodontics.com

Radiograph e-mailed: _____ Yes ______No

Our mission is to provide the highest quality of care for our patients.
Thank you for choosing our office.

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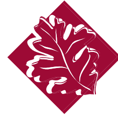

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