ALEXANDER FULLER, D.M.D.

APPOINTMENT

DAY	DATE	TIME

Introducing ____

Referring Dr. ____

Dr. Phone # ______________________ Date __________________________

PLEASE CIRCLE TEETH FOR ENDODONTIC CONSIDERATION

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

Tooth #(s) __________

PLEASE EVALUATE AND PERFORM WHICH OF THE FOLLOWING:

- ☐ Consultation and Diagnosis Only
- ☐ Root Canal Treatment
- ☐ Root Canal ReTreatment
- ☐ Internal Bleaching
- ☐ Microsurgical Endodontics
- ☐ Consultation and Treat as Necessary
- ☐ Dual Consult (Endo/Perio)
- ☐ Other____________________

Additional Comments ____

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