



Salmon Creek Endodontics
 Practice Limited to Endodontics
 14400 NE 20th Ave. Suite 100
 Vancouver, WA 98686

Phone: 360.576.5066 info@salmonendo.com
 Fax: 360.576.5059 www.salmonendo.com

Patient Name _____ Phone _____

Referred By _____ Date _____

- Root Canal Treatment Apicoectomy Surgery
 Retreatment Consultation Only

Please Circle Tooth to be Evaluated / Treated

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments _____

Restore with Temp Composite Amalgam Post & Core

Patient requests N2O Oral Sedation IV Sedation

Insurance Subscriber _____ ID# _____

Insurance Company _____ DOB _____

Appointment Date _____ **Time** _____

Signature of Referring Doctor Date



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