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

Scott George, DMD **Matt Anderson, DMD**

Patient Name_____ Phone _____

Referred By_____ Date_____

Insurance Subscriber_____ ID#_____

Insurance Company_____DOB_____

☐ **Root Canal Treatment** ☐ **Retreatment** ☐ **Apicoectomy**

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

Patient requests ☐ N2O ☐ Oral Sedation ☐ IV Sedation

Appointment Date_____Time_____

_____

Signature of Referring Doctor Date

PLEASE EMAIL / FAX COMPLETED REFERRAL TO OUR OFFICE

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