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Practice Limited to Endodontics

SEATTLE ENDODONTIC ARTS

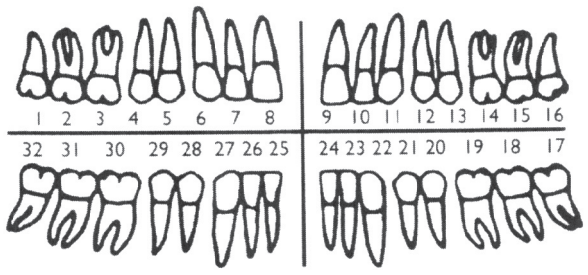
Endodontic Referral Fax

FROM: _____ DATE: _____

*PH: _____

PATIENT: _____

AREA/TOOTH OF CONCERN:



HISTORY:

- Acute Symptoms
- Chronic Symptoms
- Radiolucency
- Traumatic Injury
- Tx Complications
- Pulp Exposure

RESTORATIVE TREATMENT PLAN: _____

PROCEDURES REQUESTED:

Faxed

Date _____

Initials _____

- Evaluation Only
- Evaluation & Treatment Necessary
- Please send additional referral forms

*If you received this FAX in error, please call immediately. Thank you.