

# Michele A. Reynolds, DDS, MS

Specialist in Endodontics

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Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

For:  Consultation

Hemisection

RCT

Root Amputation

Apexification

Replantation

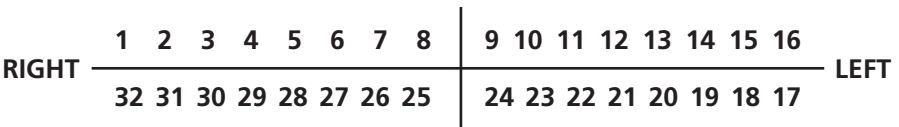
Retreat

Bleaching

Apical Surgery

Medical & Treatment History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Referring Practice \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

