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Date _____

Patient Name _____

Phone _____

For: Consultation

Hemisection

RCT

Root Amputation

Apexification

Replantation

Retreat

Bleaching

Apical Surgery

Medical & Treatment History: _____

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

Appointment Date _____ Time _____

Referring Doctor _____

Referring Practice _____

Email _____

Phone _____

Fax _____

