

# Michele A. Reynolds, DDS, MS

Specialist in Endodontics

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Date \_\_\_\_\_

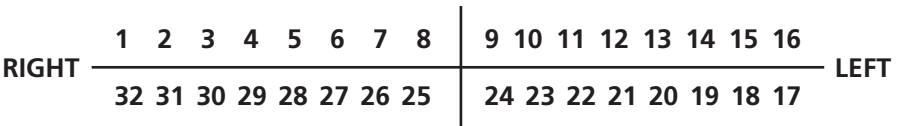
Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

- For:
- Consultation
  - RCT
  - Apexification
  - Retreat
  - Apical Surgery
  - Hemisection
  - Root Amputation
  - Replantation
  - Bleaching

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

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



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

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

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

Email \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

