MARYAM M. MONFARED, D.D.S.

PRACTICE LIMITED TO ENDODONTICS

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Introducing: _____

Referred by Dr. _____

Phone: _____ Date: _____

Please evaluate/treat tooth (teeth) # _____

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

- ❑ endodontic treatment necessary for proper restoration
- ❑ patient has discomfort, please evaluate
- ❑ crown/bridge temporarily cemented
- ❑ contact referring dentist prior to treatment
- ❑ previous endodontic treatment
- ❑ pulpotomy/pulpectomy performed
- ❑ perio/endo consult

Comments _____

_____

_____

_____

- ❑ Post space desired _____
- ❑ Please send post

Appointment date: _____ time: _____

❑ *Please check box if you would like more referral slips.*

Patient will be instructed to return to referring dentist for final resoration.