



Raymond Pandez, DDS, MSD
Endodontist

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Today's Date _____

Patient Name _____ Patient Phone _____

Referred By Dr. _____

Appointment Date _____ Time _____

PLEASE MARK TEETH TO BE TREATED

| | | | | | | | | | | | | | | | | | |
|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|
| 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 | |

TREATMENT DESIRED

- | | |
|---|--|
| <input type="radio"/> Consultation Only | <input type="radio"/> Temporary |
| <input type="radio"/> Root Canal Therapy | <input type="radio"/> Core Buildup |
| <input type="radio"/> Retreatment/Apicoectomy | <input type="radio"/> Post and Core Buildup |
| | <input type="radio"/> Post Space Preparation |

Additional Information _____



Please See Reverse Side for Office Map



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Please visit our website for additional information about our office:
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