CITRUS HEIGHTS ENDODONTICS

Practice Limited to Endodontics

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PLEASE BRING THIS REFERRAL SLIP WITH YOU

Date:_____

Introducing: _____ **Tooth #** _____

Referring Doctor: _____ **Office Phone #**_____

DESIRED TREATMENT

- ☐ Consultation Only
- ☐ Endodontic Treatment
- ☐ Prepare Post Space
- ☐ Emergency / Trama
- ☐ Other_____

Special Instructions/Comments

Scheduled Appointment

Date:_____ **Time:**_____

Please notify us 48 hrs in advance if you are unable to keep the appointment.