Lowell
Endodontics
Root Canal Specialist

Dr. John Miller DDS
Dr. Vanessa Thai DMD
Root Canal Specialist

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DATE _____

We would like to, introduce our Patient

APPOINTMENT DATE:_____ TIME: _____

PATIENT'S NAME: _____

REASON FOR REFERRAL:

- ❑ CONSULTATION
- ❑ ROOT CANAL
- ❑ RETREATMENT
- ❑ APICOECTOMY
- ❑ OTHER

TOOTH# _____ AREA OF CONCERN_____

- ❑ LEAVE POST SPACE
- ❑ FILL CANALS COMPLETELY

REMARKS/SPECIAL INSTRUCTIONS:_____

_____

_____

_____

_____

DR. REFERRING: _____

OFFICE NAME: _____

OFFICE PHONE#: _____