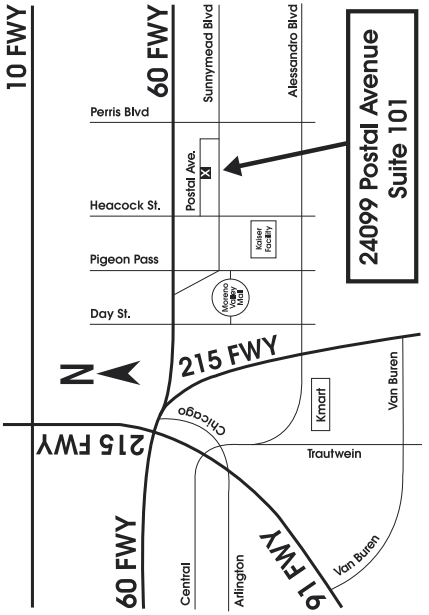

Please bring this referral to your appointment

Introducing _____

Patient Phone _____

Appointment Date_____ Time_____

1 2 3 4 5 6 7 8 : 9 10 11 12 13 14 15 16

Right Side----------Left Side

32 31 30 29 28 27 26 25 : 24 23 22 21 20 19 18 17

Remarks _____

_____

_____

_____

_____

Referring Doctor _____

Office Phone _____ Date _____

MORENO VALLEY ENDODONTICS

Lynn Diaz DDS & Associates

PRACTICE LIMITED TO ENDODONTICS

_____

24099 Postal Avenue, Suite 101
Moreno Valley, CA 92553
Phone (951) 601-1290
Fax (951) 601-1292
www.morenovalleyendodontics.com

Referring Requests:

- ❑ Consult and Treat as Necessary
- ❑ Root Canal Treatment
- ❑ Root Canal Retreatment
- ❑ Apicoectomy
- ❑ Assist with Diagnosis
- ❑ Please Call: ❑ Before Consult ❑ After Consult

Dental History:

- ❑ Pain
- ❑ Generalized Pain UR LR UL LL
- ❑ Pulp Exposure
- ❑ Trauma
- ❑ Previously Opened
- ❑ Possible Root Fracture / Crack
- ❑ Apical Pathology
- ❑ Other_____

Requested Restoration:

- ❑ Post Space
- ❑ Restore Access
- ❑ Post Buildup
- ❑ Buildup
- ❑ Other _____

3-D CBCT Imaging:

Maxillary Arch: ❑ Tooth#_____

Mandibular Arch: ❑ Tooth#_____

❑ Panorex

This time is reserved exclusively for you. Please notify the office 24 hours in advance if you are unable to keep your appointment. We are looking forward to meeting you.