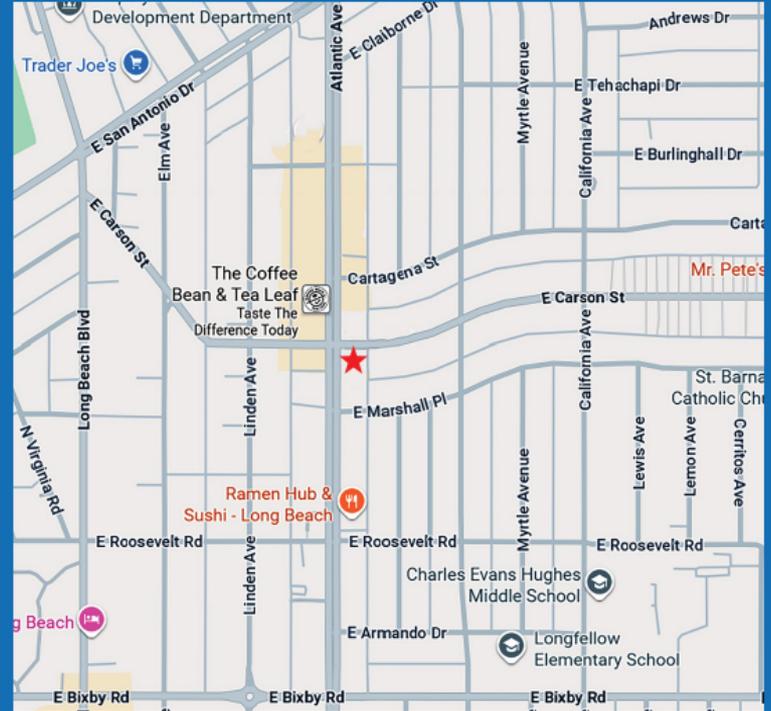


P: (562) 585-3636 F: (562) 472-0122

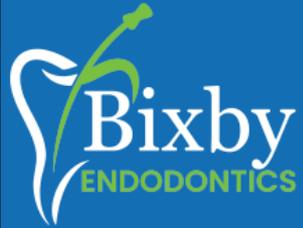
E: BixbyEndo@gmail.com

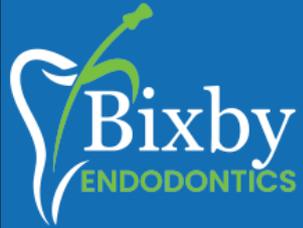
W: BixbyEndo.com

A: 612 E. Carson St., Long Beach, CA 90807



ENDODONTICS

PATIENT'S NAME		REFERRING DOCTOR	TODAY'S DATE	APPT. DATE	APPT. TIME	
TOOTH #	COMMENTS					



Please bring this slip, medical information, and insurance to your appointment — or have them emailed/messaged prior to your arrival.

TREATMENT REQUESTED	<input type="checkbox"/> CONSULTATION
	<input type="checkbox"/> ROOT CANAL TREATMENT
	<input type="checkbox"/> RETREATMENT
	<input type="checkbox"/> APICOECTOMY
	<input type="checkbox"/> INTENTIONAL RCT
	<input type="checkbox"/> CBCT OF THE FOLLOWING AREA:

POST-OP CARE	<input type="checkbox"/> SPONGE & CAVIT
	<input type="checkbox"/> CORE BUILD-UP (COMPOSITE)
	<input type="checkbox"/> POST SPACE PREPARATION
	<input type="checkbox"/> POST & CORE BUILD-UP
	OTHER: _____