

Village

ENDODONTICS

Adam Colombo, DDS

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PATIENT'S NAME _____

TOOTH #: _____

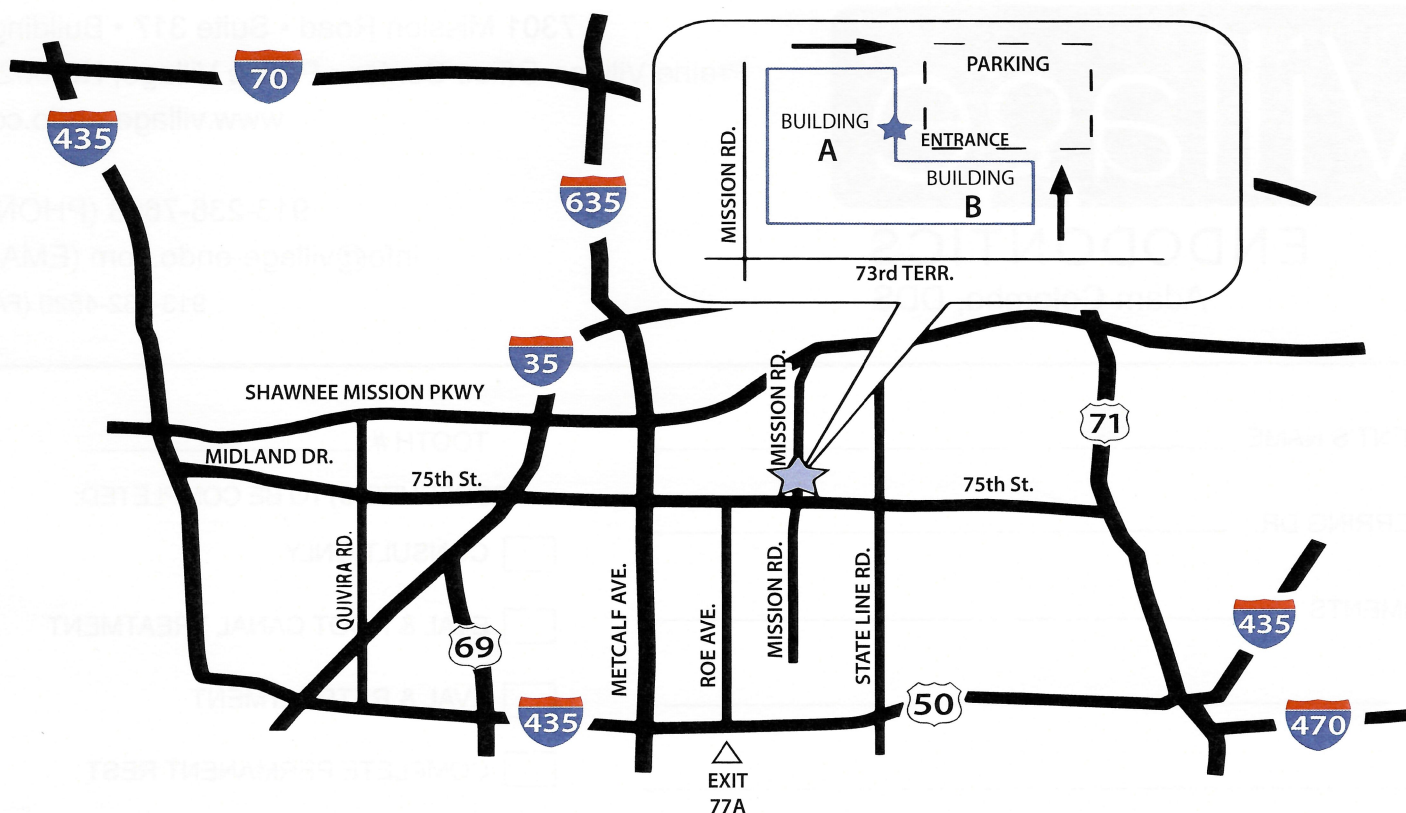
REFERRING DR. _____

PROCEDURE(S) TO BE COMPLETED:

COMMENTS _____

- ☐ CONSULT ONLY
- ☐ EVAL & ROOT CANAL TREATMENT
- ☐ EVAL & RETREATMENT
- ☐ COMPLETE PERMANENT REST
- ☐ PELLET UNDER TEMP REST

OTHER _____



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