COLORADO
ROOT CANAL
SPECIALIST

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Patient's Name:_____

Patient's Phone #:_____

Referring Doctor:_____

Appointment:_____
Date Time

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

○ Examination ○ Cone Beam CT

○ Root Canal Treatment ○ Re-Treatment / Surgical

Please Return with: ○ Temporary ○ Post Space ○ Permanent Restoration

Restorative Plan:_____

Comments:_____

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