Kirkland Endodontics

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Date: ____________________

Introducing: ____

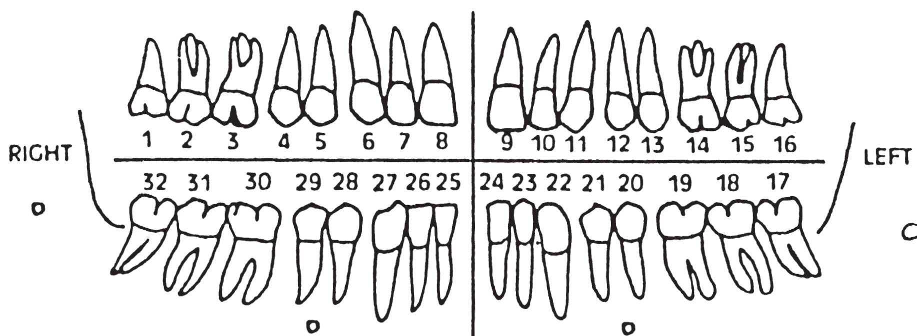
Patient Phone: ____

Referring Dentist / Dr: ____

Referring Dentist / Dr E-mail: ____

Please send digital Xrays to xrays@munsonandrude.com

Please mark teeth to be treated



- ❑ Root Canal Filling
- ❑ Examination & Pulp Test
- ❑ Apicoectomy / Retro Filling
- ❑ Pre-Med Patient
- ❑ Internal Bleach
- ❑ Post Space
- ❑ Previous Endo
- ❑ ______________

Comments, Information or Instructions: ____________________________________

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See reverse for map to our office or see our website for map and directions to our office and for insurance/financial information. Bring all insurance information with you. If you have been advised by your physician to premedicate with antibiotics before dental visits, please take the antibiotic before your first appointment. Minors should be accompanied by a parent of guardian at the first appointment.