OAK ENDODONTICS

Dr. Ahmed Matri, DDS
Endodontist

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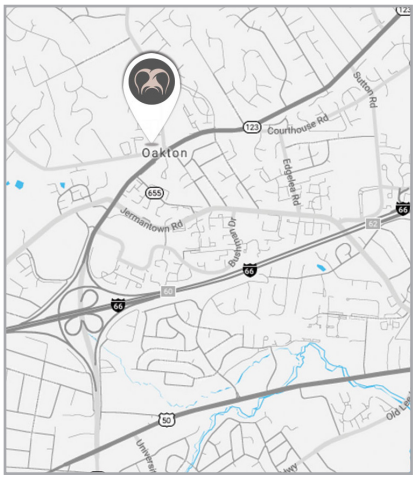
PATIENT INSTRUCTIONS

- Please call **703-272-4389** for your first appointment.
- If your dental treatment is covered by your dental insurance, please **bring the appropriate insurance forms** to your first appointment.
- **Minors** should be accompanied by a parent or a guardian.
- **Please bring this slip to your appointment.**



REFERRAL FORM

Appointment Date: _____ Time: _____

PATIENT

Name: _____

Phone: _____

TOOTH

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

Please cirle teeth for endodontic consideration.

Tooth by Name: _____

TREATMENT

Please evaluate and perform the following:

- ☐ Consultation & Diagnosis Only
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Consult & Treat as Necessary
- ☐ Intentional Endo
- ☐ Surgical Endodontics
- ☐ Internal Bleaching
- ☐ Other: _____

If exists, is the crown restoration going to be replaced?

☐ Yes ☐ No ☐ If Necessary

The following procedures are not routinely done unless requested:

- ☐ Prepare Post Space
- ☐ Place Build-up or Post & Build-up
- ☐ Other: _____

COMMENTS / SPECIAL INSTRUCTIONS

Referring Doctor: _____

Phone: _____ Date: _____