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MATTHEW LLOYD, DMD, MSD & PAUL D. CLARK, DDS, MSD
BOARD CERTIFIED ENDODONTIST

DATE: _____

PATIENT NAME: _____ DOB: _____

PATIENT PHONE: _____

REFERRED BY DR. _____

TOOTH # (AREA): _____

- ENDODONTIC EVALUATION ONLY
- EVALUATION AND ENDODONTIC TREATMENT AS INDICATED
- ENDODONTIC TREATMENT INDICATED FOR RESTORATIVE PURPOSES

PREVIOUS ROOT CANAL TREATMENT? - DATE IF KNOWN: _____

HISTORY / SYMPTOMS / SPECIAL INSTRUCTIONS:

RESTORATIVE REQUESTS:

- TEMPORIZE ACCESS OPENING
- RESTORE ACCESS OPENING WITH A PERMANENT RESTORATION
- PREPARE POST SPACE
- PLACE POST & CORE
- OTHER: _____
