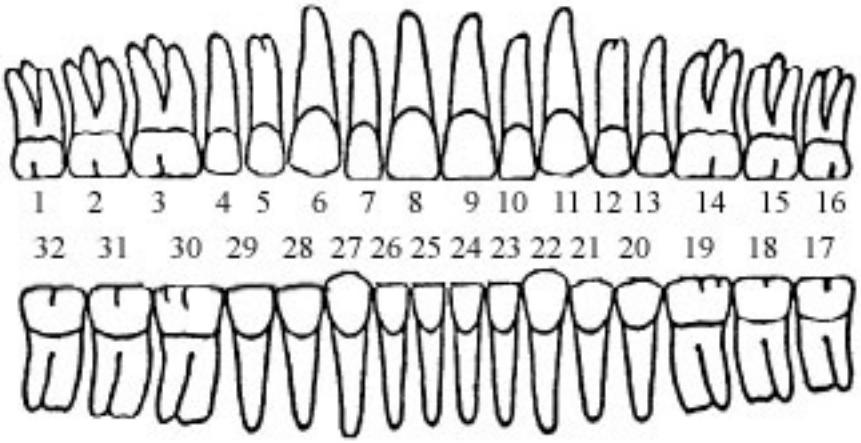
endodontic associates, ltd.

Dr. James R. Granite • Dr. Frederic H. Siegal • Dr. Francine T. Cwyk

Referral Information

Patient Name: _____

Appointment: M T W TH F Date: _____ Time: _____ AM PM



☐ Please evaluate and treat if needed

☐ Patient has vague symptoms

☐ Pulp exposed

☐ Periapical radiolucency

☐ Endodontics needed for restoration

☐ Crown is on temporarily

☐ Make post space(s)

☐ Other

Comments:

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