



**NORTH SCOTTSDALE
ENDODONTICS**

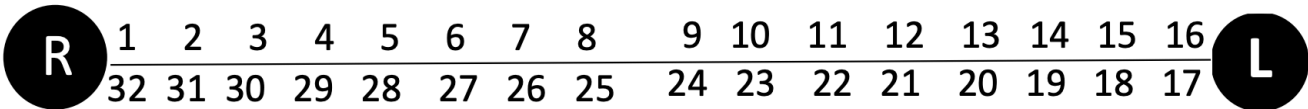
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8765 E. Bell Road Suite 213
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Patients Name: _____

Patients Phone: _____

Date: _____

Referring Doctor: _____



REFERRAL REQUEST

- Consult/Treatment Root
- Canal Therapy
- Retreatment/Apicoectomy
- Vital Pulp Therapy/Regenerative Endodontic Procedure (under 21 years of age)
- Resorption
- Oral or IV Sedation/Nitrous Oxide
- Place Buildup (and post, if needed)

COMMENTS: _____

PATIENTS: Please bring this form with you to your appointment with us
REFERRING DOCTORS: Completed form and x-rays can be emailed to
office@nsendodontics.com