LAENDODONTICS

we love to make you smile

Gabreal Shamtoub D.D.S.
smile@LAendodontist.com

Patient's Name _____ Date _____

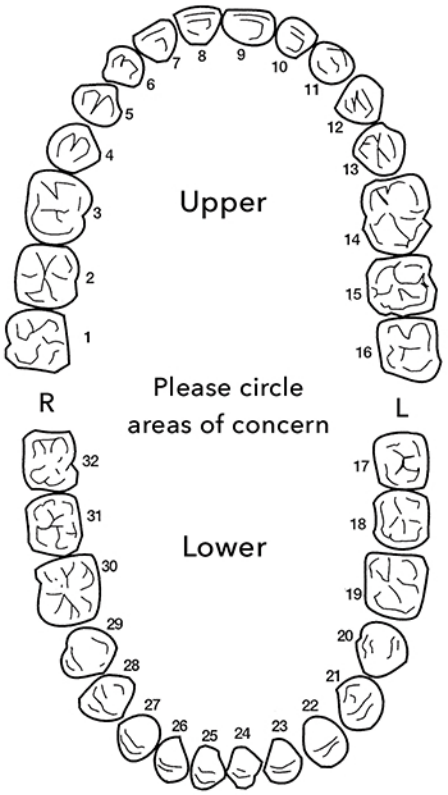
Patient's DOB _____ Patient's Phone _____

Referred By Dr _____ Phone _____

Referral Dr Address _____

Reason For Referral:

Tooth/Teeth Number(s) _____



- ☐ Consultation
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Apicoectomy
- ☐ Vital Pulp Therapy, Revascularization, Apexification
- ☐ Intentional Endodontics
- ☐ Build Up
- ☐ Post Space

Important Questions:

Will the patient receive a new crown? ☐ Yes ☐ No

What will be the patient's final restoration? _____

Crown/Bridge is cemented: ☐ Temporarily ☐ Permanently

Special Instructions _____

_____

PLEASE PRINT THIS FORM AND FAX TO OUR OFFICE

Gabreal Shamtoub D.D.S.
5567 Reseda Blvd Suite 100
Tarzana, CA 91356

FREE PARKING!
Behind the office building

Tel (818) 646-2923
Fax (818) 646-2924
www.laendodontist.com