

**PLEASE BRING TO YOUR APPOINTMENT**



S O U T H E R N A R I Z O N A  
**ENDODONTICS**

A Professional Corporation

**Direct Scheduling: 520.918.3636**

Phone: 520.322.0800

E-mail: [doctors@saendo.com](mailto:doctors@saendo.com)  
[www.saendo.com](http://www.saendo.com)

- 1011 N. Craycroft Rd., Ste 107  
Fax: 520.323.7453
- 7493 N. Oracle Rd., Ste 217  
Fax: 520.877.8889
- 512 E. Whitehouse Canyon Rd., Ste 120, Green Valley  
Fax: 520.625.6169

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Introducing: \_\_\_\_\_ DOB: \_\_\_\_\_

Referred By Dr.: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Location (if multiple offices): \_\_\_\_\_

Tooth #: \_\_\_\_\_ Has this tooth had previous endodontic treatment? Y / N

Patient is scheduled for an appointment on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ am/pm

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Root Canal Therapy      | <input type="checkbox"/> Post Space         | <input type="checkbox"/> Non Surgical Retreatment |
| <input type="checkbox"/> Pulpal Exposure         | <input type="checkbox"/> Evaluation         | <input type="checkbox"/> Apicoectomy              |
| <input type="checkbox"/> Intentional Endodontics | <input type="checkbox"/> Internal Bleaching | <input type="checkbox"/> Resorption               |

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	L

Special Instructions: \_\_\_\_\_

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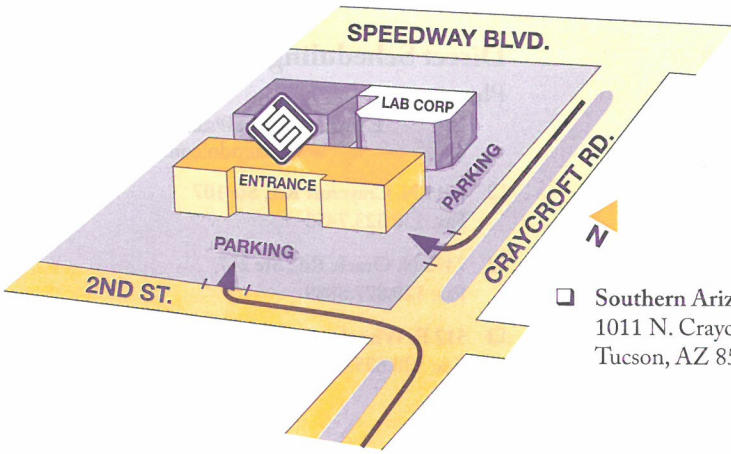


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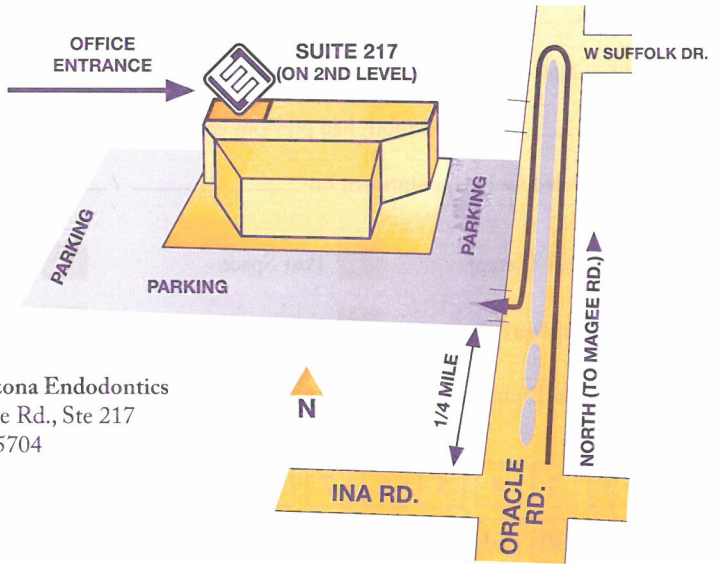
Top Copy: Patient • Bottom Copy: Referring Doctor



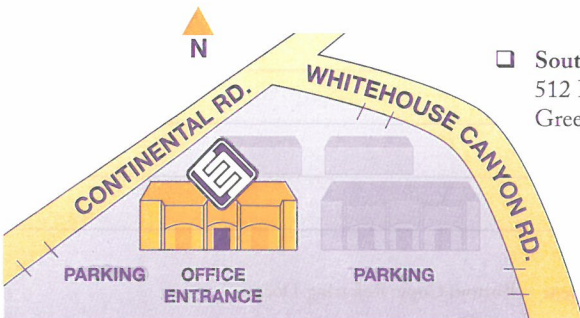
American Association of Endodontists



- Southern Arizona Endodontics  
1011 N. Craycroft Rd., Ste 107  
Tucson, AZ 85711



- Southern Arizona Endodontics  
7493 N. Oracle Rd., Ste 217  
Tucson, AZ 85704



- Southern Arizona Endodontics  
512 E. Whitehouse Canyon Rd., Ste. 120  
Green Valley, AZ 85614