Advanced Endodontics

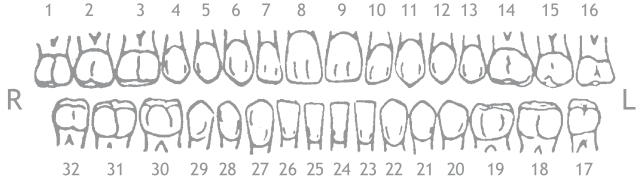
GERMÁN LUEZAS DDS, MS

Endodontic Referral Form

This is to introduce: _____

Referring Doctor: _____

Appointment Date & Time: _____



Please perform the following services:

- ❑ Diagnosis/ Exam only
- ❑ Treatment as Necessary
- ❑ Root Canal Therapy
- ❑ Apicoectomy
- ❑ Provide Post Space
- ❑ Regeneration
- ❑ Root Amputation

Special Instruction/Requests_____

THANK YOU! We truly appreciate your referrals! We promise to treat our patients with state-of-the-art expertise and personalized care. Please call us if you have any questions.

PLEASE BRING THE SLIP WITH YOU TO YOUR APPOINTMENT

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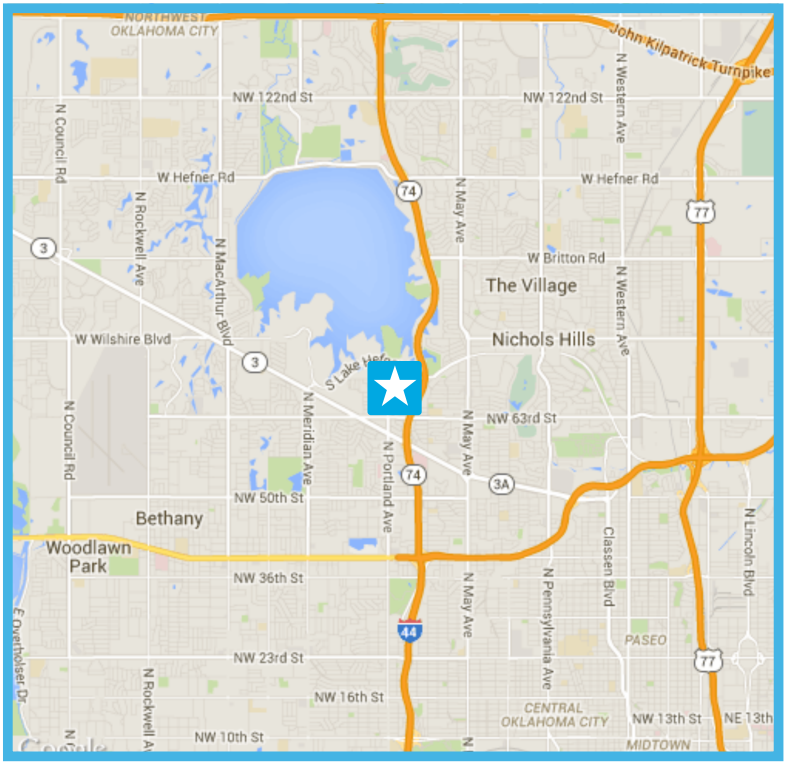

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