



METROPOLITAN ENDODONTICS

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_____ 20 _____

Introducing _____

Date of Birth _____

- Pain Radiolucency Previous RCT Resorption
- Swelling Pulp exposure History of crack

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

Referred by Dr. _____

Appointment date/time _____

- Burnsville Eden Prairie Inver Grove Heights Woodbury

Requests:

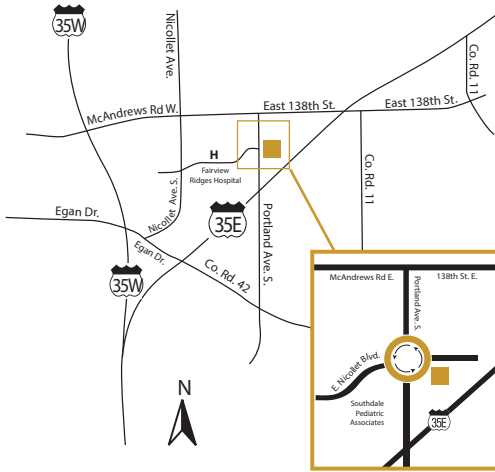
- Evaluate and treat
- Inconclusive findings.
Additional testing needed to confirm diagnosis
- Evaluate only
- Endodontic treatment necessary for proper restoration
- Endodontic treatment initiated.
- Post Space

Remarks: _____

- _____
- Temporize and return for restoration
- Restore access with:
- Discretion of Endodontist
- Composite Amalgam

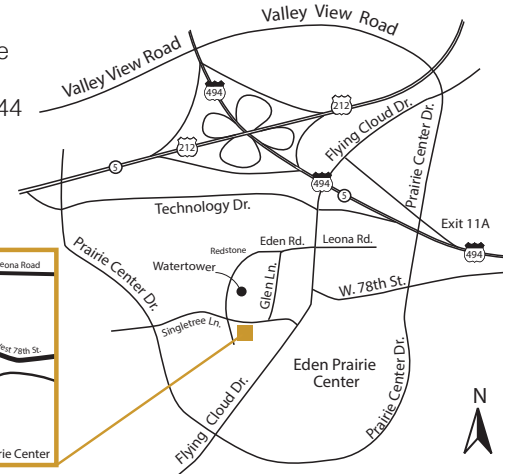
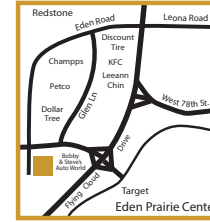
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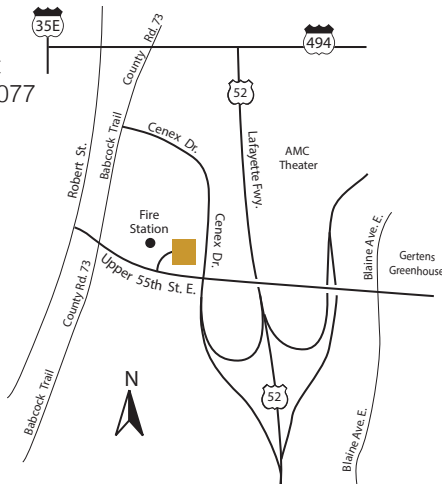
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