



WOODLANDS

ENDODONTICS

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Nicholas Pappas, DDS, MSD

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Patient's Name _____ Date _____

Patient's Phone _____

Referred by Dr. _____ Dr.'s Phone _____

PLEASE MARK TEETH TO BE TREATED

UPPER

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

LOWER

TREATMENT DESIRED

- | | |
|---|---|
| ☐ Evaluation / CBCT | ☐ Nonsurgical Root Canal Treatment |
| ☐ Nonsurgical Root Canal Retreatment | ☐ Apical Microsurgery |
| ☐ Other _____ | |

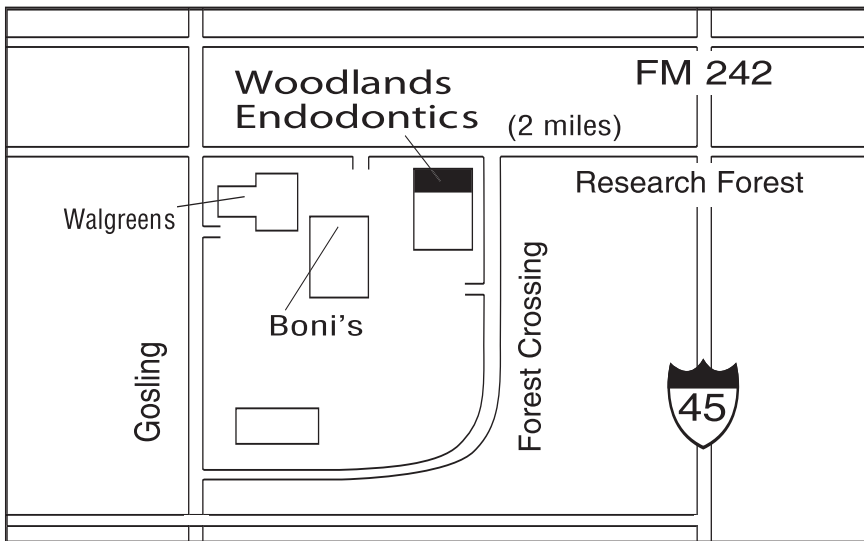
RESTORATIVE INSTRUCTIONS

- | | |
|--|---|
| ☐ Temporary Restoration | ☐ Leave Post Space |
| ☐ Permanent Restoration | |
| ☐ Comments _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |

We Save Teeth.



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INFORMATION FOR PATIENTS

PLEASE BRING TO YOUR APPOINTMENT:

- This form
- Information to complete a health history
- Dental insurance information

Our staff is happy to help you with any questions.