Sudbury Endodontics, P.C.

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DR. _____

is referring

M _____

_____

For The Date _____ and Time _____

the following tooth (teeth) require root canal treatment

	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**

Post Space: Yes No

Phone Call: Before After Not Necessary

Additional Comments: