Verne Reed, DMD, MS
Seth Perrins, DDS, MS
Don Lemire, DDS, PA

Referred by Dr. _____ Date _____

Introducing _____ for specialty care.

Patient Phone #_____

- ☐ Consultation and Diagnosis
- ☐ Root Canal Treatment
- ☐ Suspect Cracked Tooth/Root
- ☐ Retreat Root Canal
- ☐ CBCT Only- No Exam
- ☐ Post Space Needed

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	

CIRCLE TEETH FOR ENDODONTIC CONSIDERATION

Additional Remarks:_____

_____

_____

_____

_____

Appointment Made: Date _____ Time _____

West Reserve Plaza
770 W. Reserve, Suite 1
Kalispell, MT 59901

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info@flatheadendodontics.com

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