



INTRODUCING: _____
name

Appointment _____
day date time

Evaluate and treat tooth or area(s) _____

Root Canal Treatment Retreatment of previous Root Canal

Apicoectomy / Retrograde Periodontal crown lengthening request

Post and core request Post space request

I.V. Sedation requested Oral Sedation

Implant Consultation

Please contact Referring Doctor immediately: _____

Medical considerations: _____
telephone

Comments: _____

Referring Doctor _____
date

Dear Patient,

Our specialty office would like to welcome you as a patient. You will find us concerned and uniquely skilled to serve you.

Your dentist has already advised you that you may have a tooth and/or a bony endodontic (root canal) problem. Your initial visit to our office will consist of a thorough examination and discussion of the findings and options with you. If you are in acute pain, emergency pain relieving treatment will be initiated. Plan about one hour of your time for this visit.

Your initial visit will also include a financial consultation to facilitate your payment for specialty services. Please bring your insurance information/ID card, forms, etcetera. If you wish you may bring your spouse or a close family member along to listen to the consultation.

We look forward to meeting you.

DALY CITY

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Suite C
Daly City, CA 94015
Phone 650.994.2710
Fax 650.994.5313

SAN MATEO

100 So. Ellsworth Ave.
Suite 801
San Mateo, CA 94401
Phone 650.344.0299
Fax 650.344.6741

SUNNYVALE

990 W. Fremont Ave.
Suite D
Sunnyvale, CA 94087
Phone 408.736.3696
Fax 408.736.0376

LOS GATOS

14519 S. Bascom Ave.
Los Gatos, CA 95032
Phone 408.358.3750
Fax 408.358.9452