



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 Space Implant Consultation

Core Build Up I.V. Sedation

Post and Core Oral Sedation

Please Contact Referring Doctor Immediately: _____
telephone

Medical Considerations: _____

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 include a financial consultation to facilitate your payment for specialty services. Please bring your insurance information/ID card, forms, etc. 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

341 Gellert Blvd.
Suite C
Daly City, CA 94015
Phone 650.994.2710

SAN MATEO

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

SAN CARLOS

1178 Brittan Ave.
San Carlos, CA 94070
Phone 650.671.2220

SUNNYVALE

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

LOS GATOS

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

BayAreaEndo.com