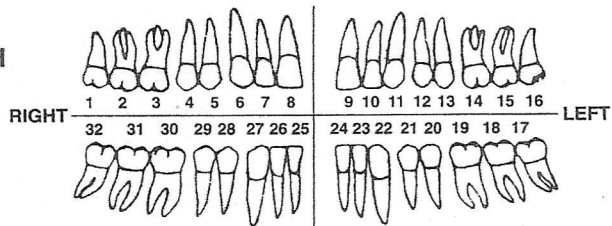


PRECISION } **ENDODONTICS**

JOY A. RIVERO, D.M.D.
EMILY WANG, D.M.D., M.S.

Introducing _____
 Cell Phone _____ E-mail _____
 Home Phone _____ Work Phone _____
 Referred by Dr. _____ Date _____

**PLEASE CIRCLE THE
AFFECTED TOOTH OR TEETH**



PLEASE CHECK THE APPROPRIATE CONDITION OR TREATMENT REQUEST

- _____ Acute Symptoms – Immediate Care Requested _____
- _____ Periapical Radiolucency _____
- _____ Pulp Exposure _____
- _____ Diffuse Pain – Please Diagnose and Treat Appropriately
- _____ Tooth Previously Treated Endodontically
- _____ Intentional Endodontic Treatment
- _____ Post Space Requested _____
- _____ Final Restoration _____ Temporary _____ Permanent

Comments: _____

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