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PRACTICE LIMITED TO ENDODONTICS
CRESTWOOD PROFESSIONAL CENTER, WEST
10682-C CRESTWOOD DRIVE
MANASSAS, VA 20109 • (703) 368-8120
WWW.MANASSASENDO.COM

Patient: _____

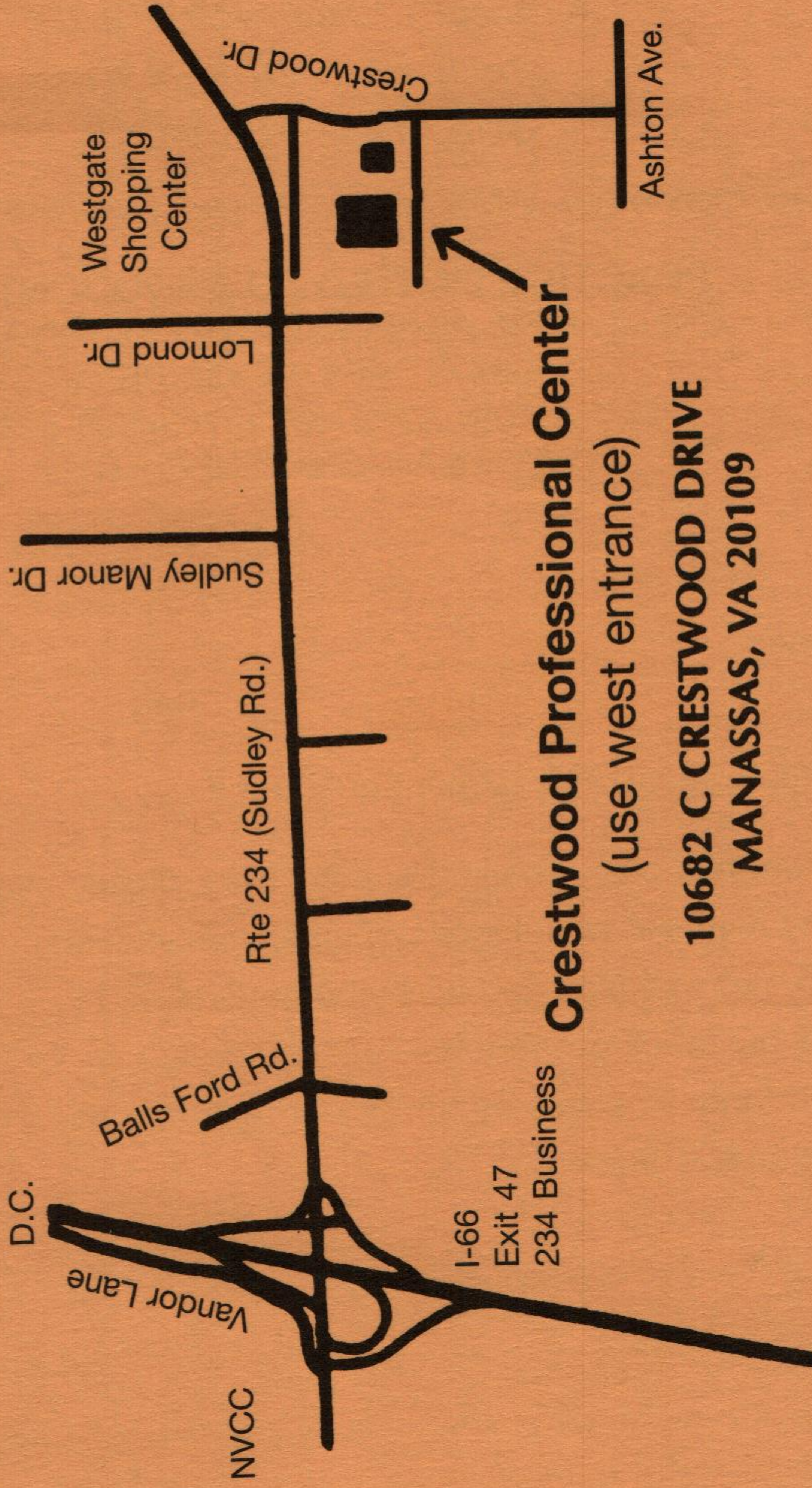
Appointment: _____
Day Date Time

Endodontic evaluation/treatment of Tooth # _____

- Patient has pain, swelling or sensitivity, please evaluate and treat.
- X-ray revealed radiolucency/pulpal involvement.
- Pulp was exposed and was vital/nonvital.
- Possible crack or fracture.
- Endodontics necessary for proper restorations.
- Post space desired.

Remark: _____

_____ Dr. _____
Date



Crestwood Professional Center
 (use west entrance)

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