MANASSAS ENDODONTICS

Matthew S. Detar DDS, MSD*
Preeti Batra BDS, MSD
Philip J. Chang DMD, MSD

* *Diplomate, American Board of Endodontics*

DATE _____ / _____ / _____

PATIENT'S NAME _____

APPOINTMENT INFORMATION

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

Date _____ / _____ / _____ Time _____ : _____ AM / PM

REFERRED BY DR. _____

Please mark teeth to be treated.

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

TREATMENT REQUESTED

❑ Consultation
❑ Root Canal Therapy
❑ Root Canal Retreatment
❑ Apicoectomy
❑ CBCT
❑ Evaluation for Dental Trauma
❑ Post Space
❑ Other _____

PATIENT PRESENTS WITH

❑ Pain
❑ Possible crack or fracture
❑ No Discomfort
❑ Swelling
❑ Pulp was exposed and was vital/non-vital
❑ Other _____

COMMENTS _____

10682 Crestwood Drive, Suite C | Manassas, VA 20109

703.368.8120 | **info@manassasendo.com** | **ManassasEndo.com**

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RADIOGRAPHS SENT ELECTRONICALLY ❑ Yes ❑ No

SCAN TO VIEW AND GET DIRECTIONS ON GOOGLE MAPS

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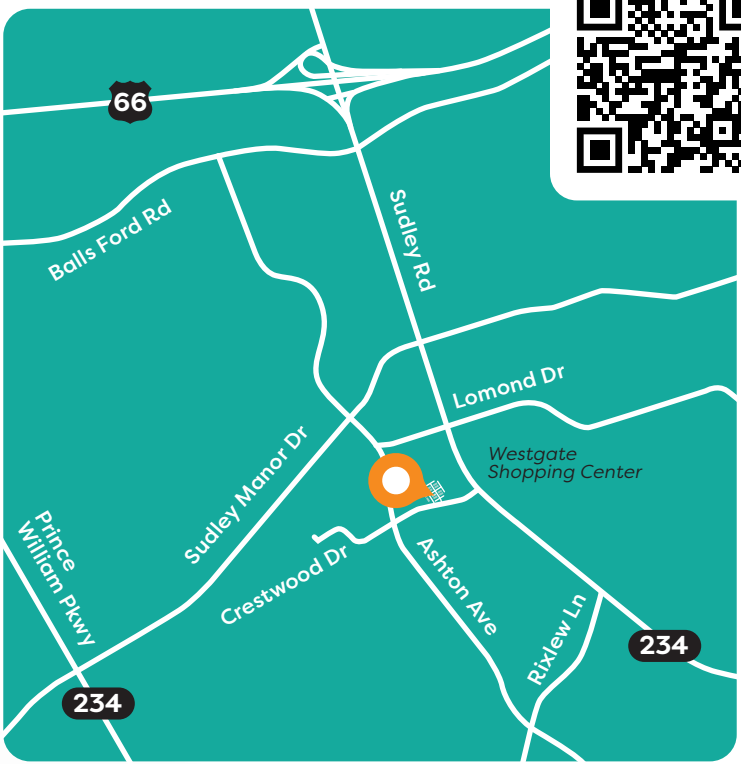
Please use the west entrance.



For more information, visit us online at **ManassasEndo.com**.