Root Canal Specialist

elm endodontics™

PETER Q. SHELLEY DDS, MS

13605 Xavier Ln. Unit E
Broomfield, CO 80020

p | 303.427.2769

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elmendo.com

Date _____

Referring Doctor _____

Patient Name _____

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

Confirm Tooth or Area _____

- ☐ Tooth is symptomatic
- ☐ Radiograph reveals pathosis
- ☐ Evaluate & treat if necessary
- ☐ Pain of uncertain origin
- ☐ Tooth has prior root canal
- ☐ Leave post space

Please email digital radiographs to info@elmendo.com

Comments _____

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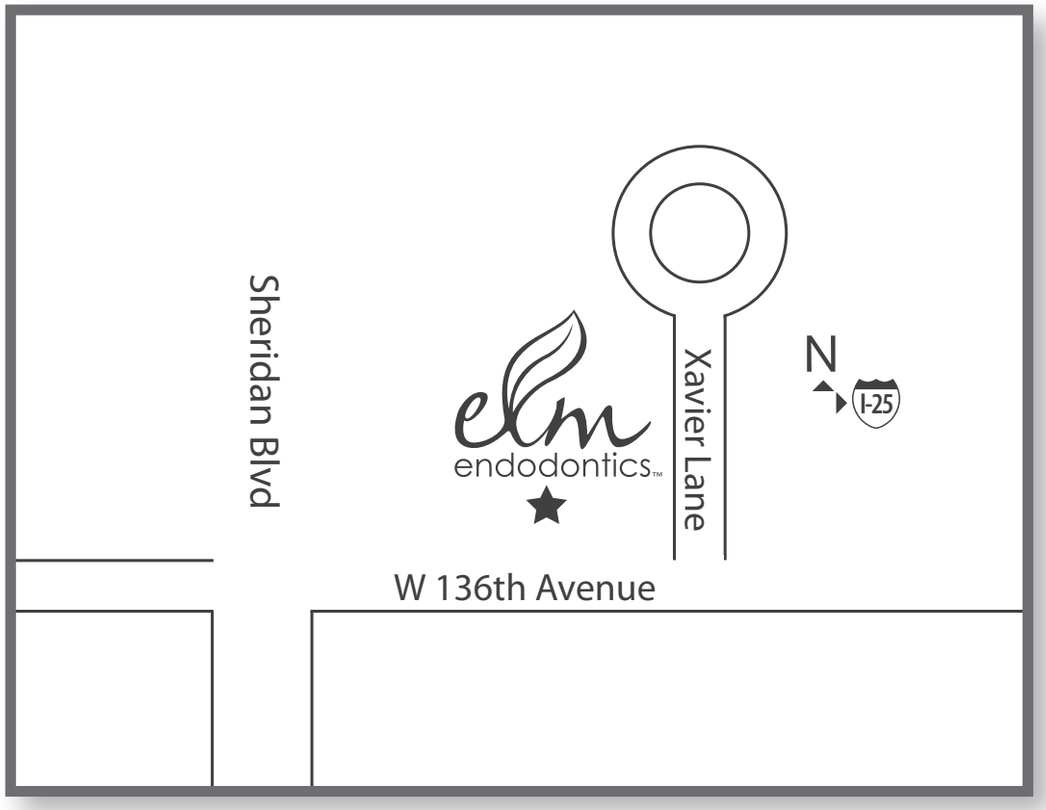

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Please bring this form with you to your appointment.
Endodontic treatment may require one or two appointments.