



ROOT CANAL
SPECIALISTS
OF ARIZONA

To schedule your appointment
please call 623-335-7339

Date _____

Patient Name _____

Patient Phone Number _____

Referring Doctor Name _____

Appt. Date _____ Appt. Time _____

**** Please bring this referral to your appointment. ****

Reason for Referral

- ☐ Root Canal Therapy Required
- ☐ Evaluate and Treat as Necessary
- ☐ Evaluate for Retreatment/Surgery

Restorative Instructions

- ☐ Provide Post Space
- ☐ Place Core Buildup
- ☐ Place Post and Core
- ☐ Temporary Filling

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		

Comments:

21250 W Roosevelt Street
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