❑ **ERNESTO PAZ JR.**, D.M.D

❑ **EILEEN M. LUJAN**, D.M.D.

Patient Name:_____ Date:_____

**PLEASE BRING THIS FORM TO YOUR APPOINTMENT**

**This patient is being referred for the following:**

- ❑ Consultation/Diagnosis
- ❑ Root Canal Therapy/Retreatment
- ❑ Apicoectomy
- ❑ Leave space for post
- ❑ Place Post/Build up as needed
- ❑ No Post / No Core

**Tooth #:**_____

Comments:_____

| UPPER RIGHT | | | | | | | | UPPER LEFT | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 |
| LOWER RIGHT | | | | | | | | LOWER LEFT | | | | | | | |

Print Doctor's name:_____


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