



Clearview Endodontics

7920 Hurontario St. Unit 38 Brampton ON L6Y 0P7

Tel: 905.454.9900 Fax: 1.905.248.3400

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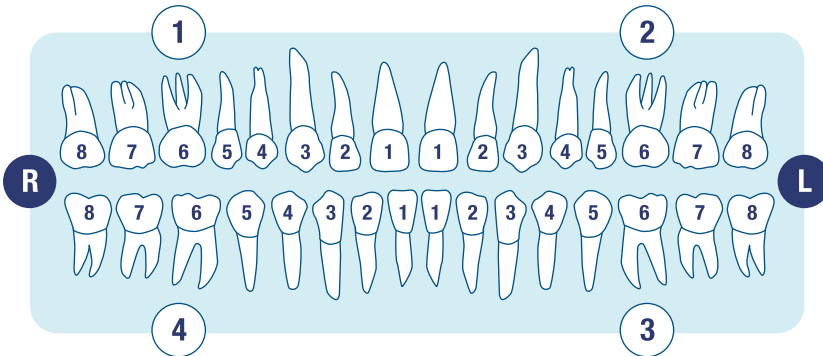
Patient: _____ Today's Date: _____

Telephone: _____ Cell: _____

Appointment: _____ Time: _____ AM/PM

Referred by Dr. _____

PLEASE CIRCLE TEETH TO BE TREATED



PROCEDURES

- Patient has pain/swelling
- X-ray has radiolucency
- Pulp was exposed
- Previous root canal
- Root canal required for restoration
- Post restoration planned
- Other: _____

Comments: _____

X-RAYS

- X-Ray Emailed
- X-Ray Mailed
- X-Ray Sent with Patient

We prefer that x-rays are emailed if your office uses digital radiography. Please email to referral@clearviewendo.com in a .jpg, .bmp or .tif format.

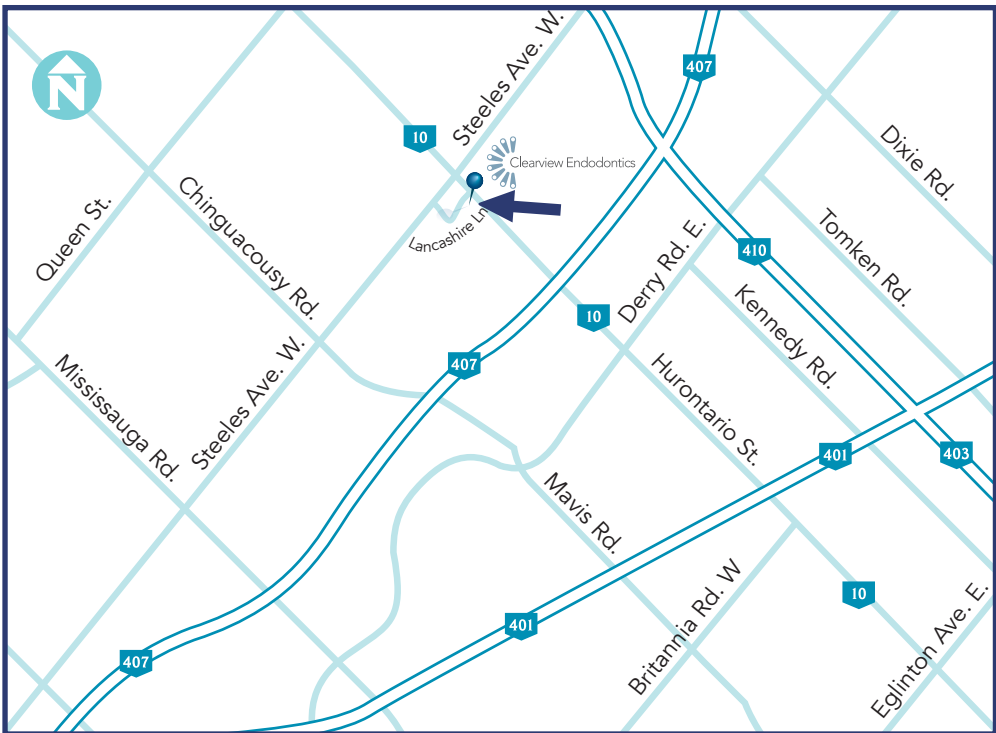
www.clearviewendo.com



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Please be advised that payment is due when services are rendered

Please allow 48 hours notice for cancellations otherwise a service charge will be applied to your account for missed appointments.