Clearview Endodontics

The Brampton Business Centre
7920 Hurontario St. Unit 38 Brampton ON L6Y 0P7
Tel: 905.454.9900 Fax: 1.905.248.3400

Diana Mastronardi BSc, DDS, FRCD(C)

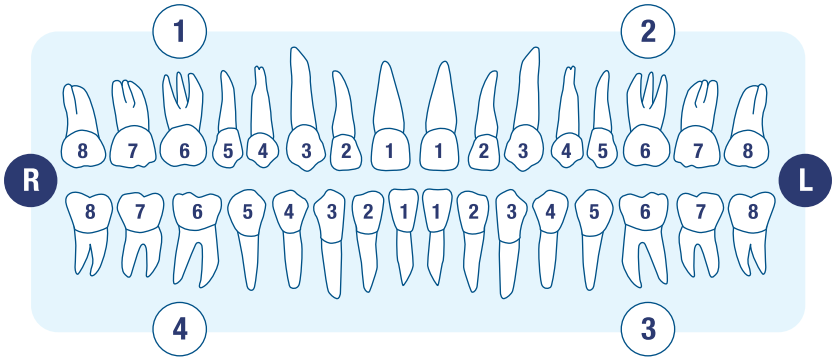
Patient: _____ Today's Date: _____

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.

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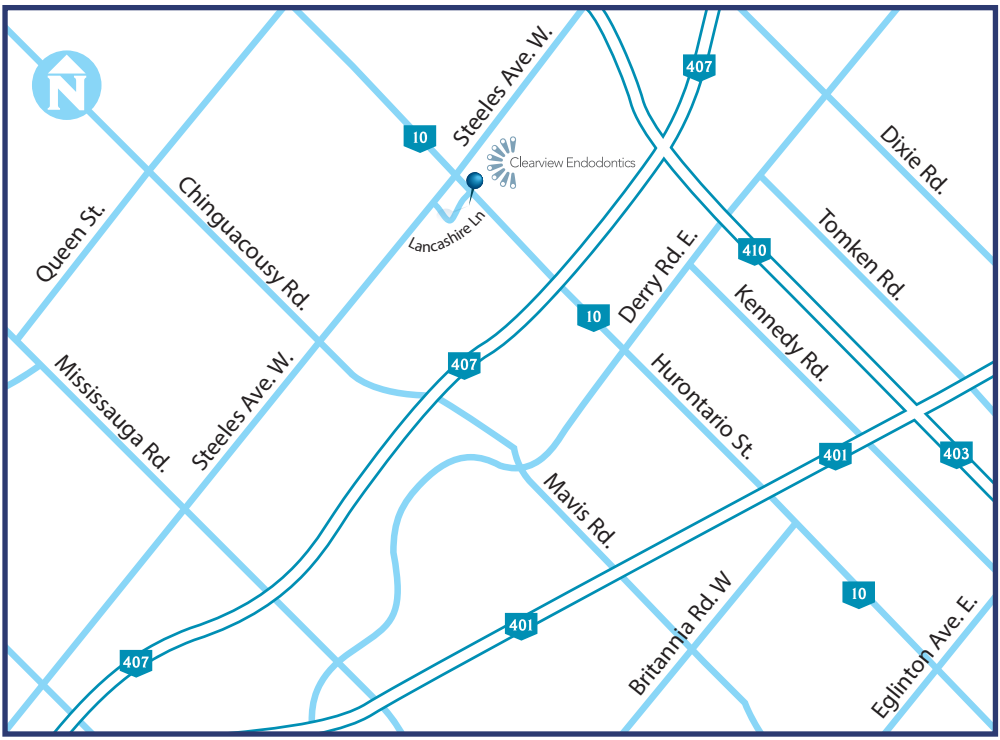

Please be advised that payment is due when services are rendered

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