Dentist

GITA SAFAIAN, DMD, MDS

Please perform the following services for Date _____

First Name _____ Last Name _____

Referring Dr. _____

- Consultation
- Root Canal Treatment
- Retreatment
- Periapical Surgery
- Diagnosis of Orofacial Pain
- Other

Tooth#

☐ 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 ☐

Post Preparation Y N

Comments

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