Patient Name:____

Referred by:____________________________________

Date:__________________

								UPPER									
Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	**Left**
Side	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	**Side**
								LOWER									

Appointment Date:____________________________________ Time:__________________

Instructions (Please Circle):

For Consultation Only | Please Call

Diagnosis & treat as needed | Prepare for post

Seal access with composite | CT Scan

Additional Remarks:

Endodontic Associates of Greater New York PC
515 Madison Avenue
Suite 715
New York, NY 10022
212-355-4444
rootcanalnyc@gmail.com
www.rootcanalnewyorkcity.com

ENTRANCE ON 53rd STREET BETWEEN MADISON AND PARK AVENUES
"E" OR "M" TRAIN TO 5th AVENUE (53rd STREET)
LEXINGTON AVENUE LOCAL (6) TO 51st STREET

Dr. Mitchell Kellert Dr. Henry Chalfin Dr. Gregory Browne Dr. Christina Boyd