WEDGEWOOD
ENDODONTICS

Chris Ettrich DDS, MSD

Introducing _____ **Date** _____

Referring dentist _____ **Phone number** _____

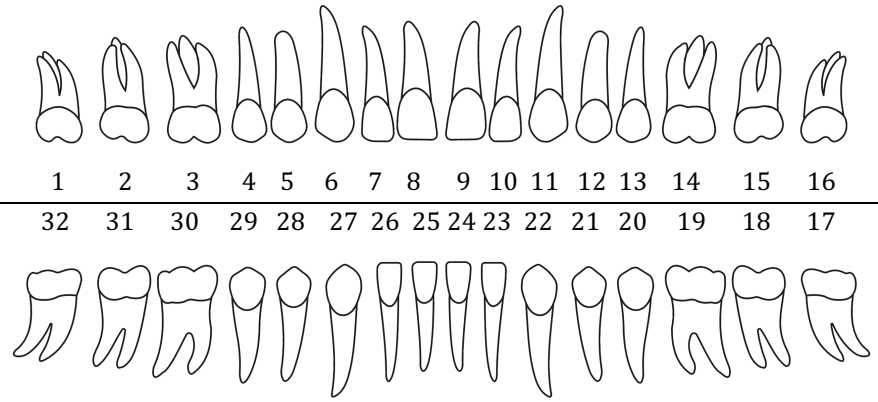
☐ Patient already scheduled

Date of appointment _____ Time of appointment _____

☐ Call patient to schedule

Home phone _____ Work phone _____

Please indicate teeth or area that may need treatment:



Reason for referral:

- ☐ Evaluation, consultation only
- ☐ Root canal therapy as indication – Tooth # _____
- ☐ Prepare post space _____ canal(s)
- ☐ Retreatment case
- ☐ Bleach

Surgical Endodontics:

- ☐ Apical surgery
- ☐ Biopsy
- ☐ Perforation/resorption repair

Other helpful information or comments:

_____

_____

_____

9773 Fairway Drive, Powell, Ohio 43065 Ph: 614-789-ENDO (3636) Fx: 614-789-5797
www.wedgeendo.com info@wedgeendo.com
Hours: Mon – Fri, 8:00 am – 4:30 pm