All locations now have a CBCT Scanner

9 Convenient Locations in the Tri-County Area
Carl M. Botvinick, D.D.S.
Michael A. Glass, D.D.S.
Richard Rubinstein, D.D.S.
Richard J. Gardner, D.D.S.
Gerald C. Dietz, Jr., D.D.S.
Alayne Evans, D.D.S.

Stephen Navarre, D.D.S.
Mark Robinson, D.M.D.
Tiffany Chimelak, D.D.S.
Craig F. Duhaime, D.D.S.
James Nowicki, D.D.S.
Ross Ryan, D.D.S.

Chad Speirs, D.M.D.
Neema Mehrkhodavandi, D.D.S.
Tony Tran, D.D.S.
Mark Shallal-Ayzin, D.D.S.
John Lindell, D.D.S.
Cara McCary, D.M.D.

An Extension of your Practice®

Date: ______________________

Introducing _________________________________________________________________________

Appointment Date: ______________________________________ Time: ____________________

Referring Doctor: ______________________________________________________________________

Instructions: __________________________________________________________________________

_____________________________________________________________________________________

To Be Filled In By Dentist:

☐ Nerve was exposed.  ☐ Panorex
☐ X-Ray revealed radiolucency.  ☐ Limited View CBCT Image
☐ Root Canal treatment was started.
☐ Post prep is indicated.
☐ Evaluation for possible surgery.
☐ Retreatment.
☐ Patient is having pain, swelling, sensitivity.
☐ Endodontic treatment is necessary for proper restoration of tooth.

<table>
<thead>
<tr>
<th>Upper</th>
<th>Molars</th>
<th>Right Bicuspid</th>
<th>Anteriors</th>
<th>Anteriors</th>
<th>Left Bicuspid</th>
<th>Molars</th>
</tr>
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<td>1</td>
<td>2 3</td>
<td>4 5</td>
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<td>15 16</td>
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<tr>
<td>Lower</td>
<td>32 31 30</td>
<td>29 28</td>
<td>27 26 25</td>
<td>24 23 22</td>
<td>21 20 19 18</td>
<td>17</td>
</tr>
</tbody>
</table>

(circle teeth for endodontic consideration)

Information for Patient:

• You will be returning to your family dentist for final restoration after treatment.
• When calling for your appointment, please have your dental insurance information available.
• Please bring this referral slip and your dental insurance information to your appointment.

Please Mark the Office Where Patient is to be Treated:

☐ BLOOMFIELD HILLS - TROY ...................................................... (248) 647-7930 (248) 647-0576
☐ WATERFORD - PONTIAC ....................................................... (248) 683-2300 (248) 683-2597
☐ CLINTON TWP. - STERLING HTS. ............................................ (586) 286-3390 (586) 286-0287
☐ ROCHESTER - LAKE ORION .................................................... (248) 656-1626 (248) 656-3147
☐ FARMINGTON HILLS - W. BLOOMFIELD .................................... (248) 737-1360 (248) 737-0291
☐ CLARKSTON - NORTH OAKLAND .............................................. (248) 620-0002 (248) 620-0025
☐ ANN ARBOR - YPSILANTI ..................................................... (734) 761-3166 (734) 761-3831
☐ COMMERCE TWP. - WHITE LAKE ............................................. (248) 363-9345 (248) 363-9346
☐ NOVI-NORTHVILLE ............................................................. (248) 427-0488 (248) 427-0588

For registration forms visit our website at www.rootcanalinfo.com

Location maps on reverse side
FOR ADDITIONAL REFERRAL SLIPS
PLEASE FILL OUT
YOUR NAME AND ADDRESS BELOW

DR. __________________________________________________________
ADDRESS _____________________________________________________

________________________________________________________________

Please send _____________ pad(s).

Tear along perforation, fill out and mail upper portion of card.

OR FAX THIS FORM TO: 248-647-6067

Thank you for your confidence in us when referring your endodontic patients.

“An Extension of Your Practice”®