All locations now have a CBCT Scanner

9 Convenient Locations in the Tri-County Area
Date: ______________________

Introducing _____________________________________________________________________

Appointment Date: ______________________________________ Time: ____________________

Referring Doctor: _________________________________________________________________

Instructions: _____________________________________________________________________

_______________________________________________________________________________

To Be Filled In By Dentist:

☐ Nerve was exposed.
☐ X-Ray revealed radiolucency.
☐ 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>Left Bicuspids</th>
<th>Right Bicuspids</th>
<th>Molars</th>
<th>Anteriors</th>
<th>Anteriors</th>
<th>Molars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Lower</td>
<td>32</td>
<td>31</td>
<td>30</td>
<td>29</td>
<td>28</td>
<td>27</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 MORE DETAILED DIRECTIONS PLEASE VISIT OUR WEBSITE AT: www.rootcanalinfo.com
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”®