

ENDODONTIC



ASSOCIATES

“An Extension of Your Practice”[®]



All locations now have a CBCT Scanner

**9 Convenient Locations
in the Tri-County Area**



ASSOCIATES

Gerald C. Dietz, Jr., D.D.S.
 Stephen Navarre, D.D.S.
 Mark Robinson, D.M.D.
 Craig F. Duhaime, D.D.S.
 James Nowicki, D.D.S.

Mark Shallal-Ayzin, D.D.S.
 Michael A. Glass, D.D.S.
 Tiffany Chimelak, D.D.S.
 Amruta Mahajan, B.D.S.
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Rutuja Jadhav, M.D.S.
 David Karwacki, D.D.S.
 Hafsa Affendi, B.D.S.
 Gianni DeCarolis, D.M.D.
 Cassandra Wieczerza, D.D.S.

An Extension of your Practice®

Date: _____

Introducing _____

Appointment Date: _____ Time: _____

Referring Doctor: _____

Instructions: _____

To Be Filled In By Dentist:

- | | |
|--|---|
| <input type="checkbox"/> Nerve was exposed. | <input type="checkbox"/> Evaluation for possible surgery. |
| <input type="checkbox"/> X-Ray revealed radiolucency. | <input type="checkbox"/> Retreatment. |
| <input type="checkbox"/> Root Canal treatment was started. | <input type="checkbox"/> Limited View CBCT Image |
| <input type="checkbox"/> Patient is having pain, swelling, sensitivity. | <input type="checkbox"/> Post prep is indicated. |
| <input type="checkbox"/> Endodontic treatment is necessary for proper restoration. | |

	Molars			Right Bicuspid		Anteriors			Anteriors			Left Bicuspid		Molars		
Upper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Lower	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

(circle teeth for endodontic consideration)

Information for Patient:

- For registration forms visit our website at www.rootcanalinfo.com
- 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.
- You will be returning to your family dentist for final restoration after treatment.

Please Mark the Office Where Patient is to be Treated:

Phone

Fax

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

Office addresses and phone numbers on reverse side

LOCATIONS AND PHONE NUMBERS

- BLOOMFIELD HILLS-TROY**.....(248) 647-7930
50 W. Big Beaver, Ste. 200, Bloomfield Hills, MI 48304
1/2 block east of Woodward, Bloomfield Hills
- WATERFORD-PONTIAC**(248) 683-2300
2335 Pontiac Lake Rd., Ste. D, Waterford, MI 48328
West of Telegraph
- CLINTON TWP.-STERLING HEIGHTS**.....(586) 286-3390
15870 19 Mile Rd., Ste. 110, Clinton Twp., MI 48038
Lincoln Center Building 100
- ROCHESTER-LAKE ORION**(248) 656-1626
1460 Walton Blvd., Ste. 208, Rochester, MI 48309
Park at rear door C or D
- FARMINGTON HILLS-WEST BLOOMFIELD**.....(248) 737-1360
31410 Northwestern Hwy., Ste. C, Farmington Hills, MI 48334
Access to office only off of northbound Northwestern
- CLARKSTON-NORTH OAKLAND**(248) 620-0002
5825 S. Main St., Ste 103, Clarkston, MI 48346
Munk Professional Center
- ANN ARBOR-YPSILANTI**(734) 761-3166
315 E. Eisenhower Pkwy., Ste. 220, Ann Arbor, MI 48108
Burlington Office Center II
- COMMERCE TWP.-WHITE LAKE** (248) 363-9345
2900 Union Lake Road, Ste. 218, Commerce, MI 48382
Lakes Professional Plaza
- NOVI-NORTHVILLE**(248) 427-0488
25500 Meadowbrook, Ste. 125, Novi, MI 48375
Meadowbrook Medical Center

FOR MORE DETAILED DIRECTIONS: 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"®



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 448 BLOOMFIELD HILLS, MI

POSTAGE WILL BE PAID BY THE ADDRESSEE

ENDODONTIC ASSOCIATES
50 W BIG BEAVER RD STE 200
BLOOMFIELD HILLS MI 48304-3912

