Martin J. Rogers, D.D.S. | **Paulina Erdle,** D.M.D.
John Tran D.M.D., M.S.

Best Endodontics *of Glenview*

MICROSCOPIC ROOT CANAL THERAPY

1775 Glenview Road, Suite 217 | Glenview, Illinois 60025
T 847 729 8400 | F 847 729 8408 | www.bestendoglenview.com

REFERRAL SLIP

Date _____

Introducing _____

Referred by Dr. _____

TOOTH

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

☐ Composite Core Buildup

☐ **POST ROOM** YES NO (please circle)

REMARKS _____

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PATIENTS:

1. Please bring this referral slip with you on the day of your appointment.
2. If you are taking any medications, please bring their names with you. The names are usually printed on the prescription bottle.
3. If you have dental insurance, please bring your card with you on the day of your appointment.

Payment is expected at the time of service unless prior arrangements are made.