



brisbane microsurgical endodontics
root canal therapy
endodontic microsurgery

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Registered Specialist Endodontists

DATE / /

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Patient

Name

Address

.....

.....

Phone

Email

D.O.B / /

Practitioner

Name

Address

.....

.....

Phone

Email

Clinical Notes (including relevant medical history):

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The patient's **current pain level** is: ☐ Nil ☐ Mild ☐ Moderate ☐ Severe

Please indicate the **restorative plan** for any teeth to be treated and if post space is required:

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.....

Enclosed radiographs:

Regarding this patient, would you like to be contacted by: ☐ Phone ☐ Letter ☐ Email

Signed