

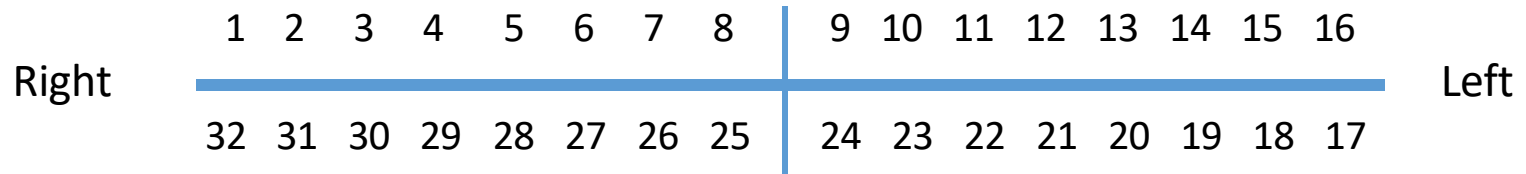
**Bernardo F. Sarmiento Jr., DDS. MSD.**  
Endodontist



Patient's Name: \_\_\_\_\_  
Patient's Phone Number: \_\_\_\_\_  
Date: \_\_\_\_\_  
Referring Dentist: \_\_\_\_\_  
Office Phone Number: \_\_\_\_\_

“Striving for Quality Excellence in Root Canal Therapy”

Select Tooth / Area of Concern



Select Desired Treatment

- Evaluation / CBCT LFOV 4x4 Scan       RCT       Retreatment  
 Post space       Post Placement       I & D       Apicoectomy

Comments: \_\_\_\_\_

Restore Endodontic Access

- Temporary filling       Core build-up

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