



"Striving for Quality Excellence in Root Canal Therapy"

Bernardo F. Sarmiento DDS, MSD.
Endodontist

Patient's Name: _____

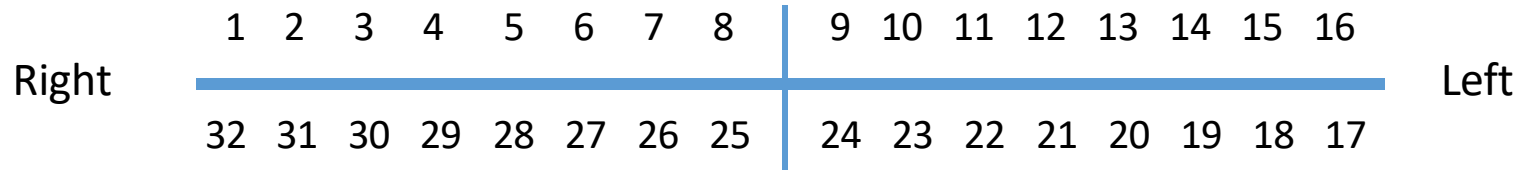
Patient's Phone Number: _____

Date: _____

Referring Dentist: _____

Office Phone Number: _____

Select Tooth / Area of Concern



Select Desired Treatment

- | | | | |
|--|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Evaluation / CBCT LFOV 4x4 Scan | <input type="checkbox"/> RCT | <input type="checkbox"/> Retreatment | |
| <input type="checkbox"/> Post space | <input type="checkbox"/> Post Placement | <input type="checkbox"/> I & D | <input type="checkbox"/> Apicoectomy |

Comments: _____

Restore Endodontic Access

- | | |
|--|--|
| <input type="checkbox"/> Temporary filling | <input type="checkbox"/> Core build-up |
|--|--|

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