

PATIENT'S NAME _____ APPOINTMENT
 DATE _____ TIME _____

REFERRED FOR: CONSULTATION ONLY RCT POST
 OTHER _____ POST SPACE ONLY

RIGHT								LEFT							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

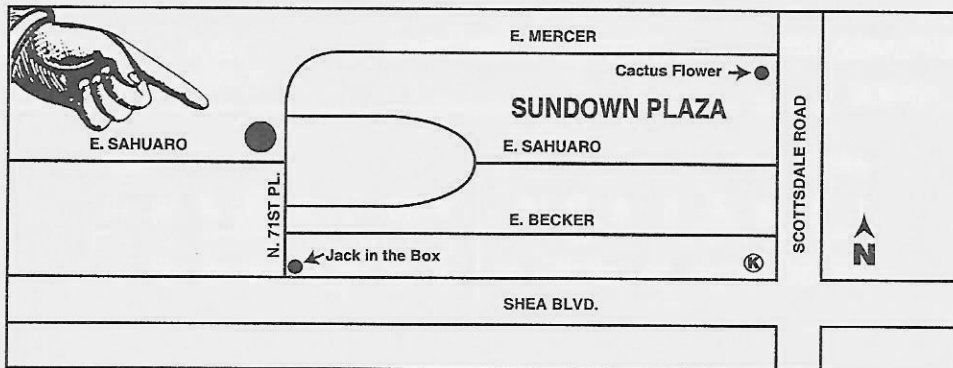
RADIOGRAPHS SENT BY MAIL WITH PATIENT PLEASE TAKE

REFERRED BY DR. _____

PLEASE CALL ME AT _____
 (PHONE NUMBER)

N₂O Analgesia and TLC always available

SCOTTSDALE ENDODONTICS, P.C.
 Michael A. Markson, D.M.D.
 Ryan H. Engelberg, D.D.S.



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 PLEASE BRING THIS REFERRAL NOTICE WITH YOU ON THE DAY OF YOUR APPOINTMENT