Patient Referral Card

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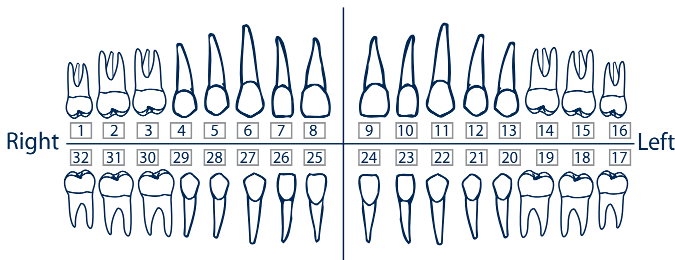
CLEVELAND LEADERS IN ENDODONTICS
PRACTICE LIMITED TO ENDODONTICS

Name: ____

Date: ____

Referred By: ______________________________________

Please mark the tooth/teeth involved:



☐ Consultation – Evaluation

☐ Initial Treatment – Endo Required

☐ Retreatment

☐ Leave Post Space

Please provide us with any additional information that may assist us in caring for your patient:

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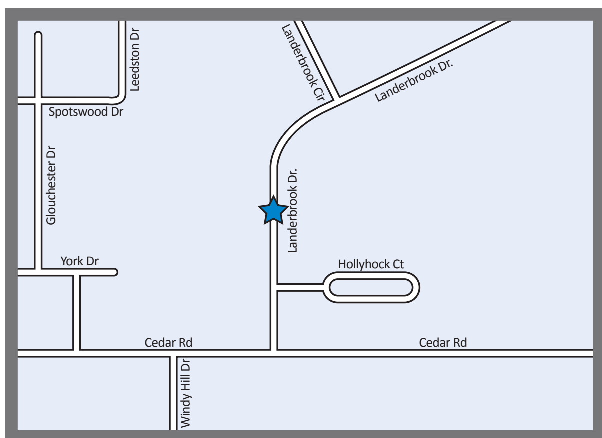
GUARDIAN

Humana

MEDICAL MUTUAL

MetLife



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