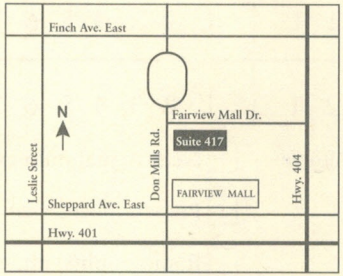
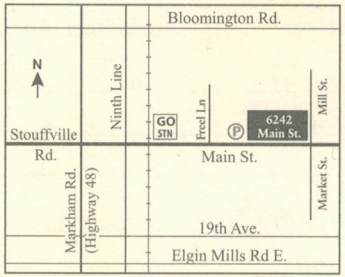
SUGGESTIONS FOR PATIENTS

1. Please call for the first appointment.
2. If you are taking medications, please bring them with you or write the name and dose of the medication, the amount and times taken.
3. Minors must be accompanied by a parent or guardian.
4. Fees are payable during or upon completion of therapy.



North York



Stouffville

Lisa C.Y. Wong *Endodontist* M.Sc., D.M.D., F.R.C.D. (C)
Sophia Lalani *Endodontist* D.M.D., F.R.C.D. (C)

☐ 5 Fairview Mall Drive, Suite 417, North York, Ontario M2J 2Z1
Tel. 416.490.9998 Fax. 416.493.9997
☐ 6242 Main Street, Stouffville, Ontario L4A 1E2
Tel. 905.640.0161 Fax. 905.640.5355
email: fairviewendo@on.aibn.com
www.myrootcanal.ca

Introducing _____

For consideration of the following tooth (teeth):

1 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 2
RIGHT	LEFT
4 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 3

☐ Consultation and diagnosis
☐ Near/Actual pulp exposure
☐ Non-surgical root canal therapy
☐ Prepare post space
☐ Retreatment
☐ Radiograph(s) attached
☐ Apicoectomy-retrofill
☐ Trauma/Open Apex

Appointment on _____ at _____ o'clock

Special instructions/remarks _____

_____

Referred by Dr. _____

Location _____