THORNHILL
ENDODONTICS

DR. SHAUL DWOSH
DR. ALISON FIELDS
DR. GILLIAN LANDZBERG

This is to introduce: _____

The following time has been reserved for your care in our office:

Day_____ Date _____ Time _____ a.m. / p.m.

We kindly ask that you arrive 15 minutes prior to your appointment.

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

For the following:

- ☐ Root Canal Treatment
- ☐ Root End Microsurgery
- ☐ Retreatment
- ☐ Other _____
- ☐ CBCT Imaging Requested

Reason for referral: _____

_____

Patient has been prescribed:

Antibiotic: _____

Analgesic / NSAID: _____

Special Instructions / Remarks: Prepare post space ☐ yes / ☐ no

_____

_____

- ☐ Radiograph(s) emailed
- ☐ Contact me personally before / after seeing patient

Referred by: Dr. _____ Phone: _____

Specialists in Root Canal Therapy

DR. GILLIAN LANDZBERG
DR. ALISON FIELDS
DR. SHAUL DWOSH

THORNHILL ENDODONTICS

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