

*Paul A. Shepherd, D.M.D., M.S.*

Practice limited to Endodontics

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**This is to introduce:** \_\_\_\_\_

**From Dr.** \_\_\_\_\_

Who is referred to your office on:

Day

Date

For Endodontic Consideration:

☐

CONSULTATION AND DIAGNOSIS

☐

COMPLETE ROOT CANAL THERAPY

☐

RETREAT OF OLD ROOT CANAL

☐

OTHER \_\_\_\_\_

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

TOOTH OR AREA IN QUESTION IS:

UPPER

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

LOWER

MAP PROVIDED ON BACK. PLEASE CALL OUR OFFICE SHOULD YOU HAVE ANY QUESTIONS.

