



**Bernard W Harrington DDS
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Virginia
108 North 3rd Ave
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Duluth
210 West Central Entrance
Duluth, MN 55811

Patient's Name: _____

Phone Number: _____

Referred By: _____

Date: _____

For Endodontic Consideration

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

Referral for the Following:

- Consultation & Diagnosis
- Root Canal Therapy
- Re-Treatment
- Surgical Evaluation / Apicoectomy
- Extraction and Socket Preservation

Restoration Request:

- Core Buildup
- Temporary w/ cotton pellet
- Composite

Remarks: _____

Please Call Me: Before Treatment After Treatment

Please arrive 20 minutes early with a copy of this form. Please bring a list of your medications and your insurance card.

* In many instances, root canal treatment can not be successful without a timely permanent filling.

See reverse side for map

