



DOMINION ENDODONTICS

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ALEXANDRIA: 703.836.0006 | FALLS CHURCH: 703.534.0330 | ARLINGTON: 703.940.3070

Today's Date: _____

Patient's Name: _____

Referred by Dr: _____

Doctor Choice: Dr. Palmieri Dr. Schoenly Dr. Portell First Available

PLEASE MARK TEETH TO BE TREATED

UPPER

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

LOWER

- | | |
|--|--|
| <input type="checkbox"/> Root Canal Therapy | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> Root Canal Retreatment | <input type="checkbox"/> Evaluation |
| <input type="checkbox"/> Apicoectomy Surgery | <input type="checkbox"/> Core Build-Up |
| <input type="checkbox"/> Radiographs Sent Electronically | <input type="checkbox"/> Post Space (Para Flexi Fiber) |

PLEASE SEE REVERSE SIDE FOR APPOINTMENT INFORMATION

WWW.DOMINIONENDODONTICS.COM

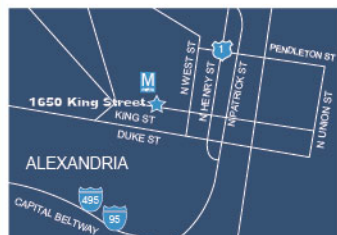
APPOINTMENT INFORMATION

MON TUES WED THURS FRI
DATE: _____ AT: _____ AM / PM

1. Please bring this referral form with you to your appointment; it contains important information about your treatment.
2. Fees are payable at time of service.
3. If you have dental insurance, please bring your insurance card.
4. If digital radiographs are provided by your dentist, they must be received by our office the day prior to the appointment. This does not preclude the possible need for additional radiographs in our office.
5. Minors must be accompanied by parent or legal guardian during appointment.
6. Please visit our website at WWW.DOMINIONENDODONTICS.COM to complete forms and to learn more about our practice.

☐ ALEXANDRIA OFFICE

1650 KING STREET, SUITE 300
ALEXANDRIA, VIRGINIA 22314
703.836.0006



☐ FALLS CHURCH OFFICE

7115 LEESBURG PIKE, SUITE 309
FALLS CHURCH, VIRGINIA 22043
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☐ ARLINGTON OFFICE

4350 FAIRFAX DR., SUITE 160
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