



ENDODONTIC THERAPY
Mario Abdennour D.M.D., M.M.Sc.

Specialized in Microscope Guided
 Conventional and Surgical Endodontics

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Appointment Made For: _____

Appointment Date: _____

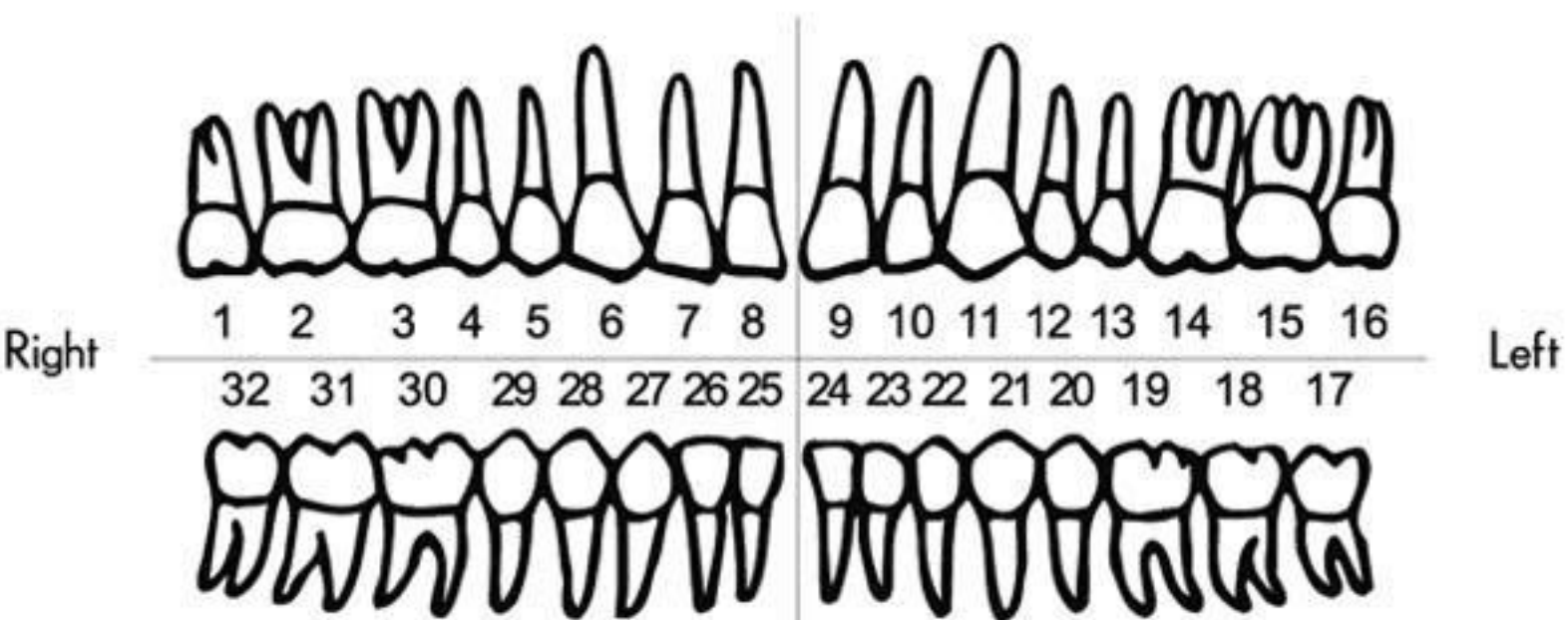
*This time is reserved specifically for you. If by necessity you must cancel your appointment, please notify us at least **24 hours** in advance.*

Referring Doctor: _____

Referring Dr.'s Phone: _____

Today's Date: _____

PLEASE EVALUATE / TREAT THE FOLLOWING TEETH:



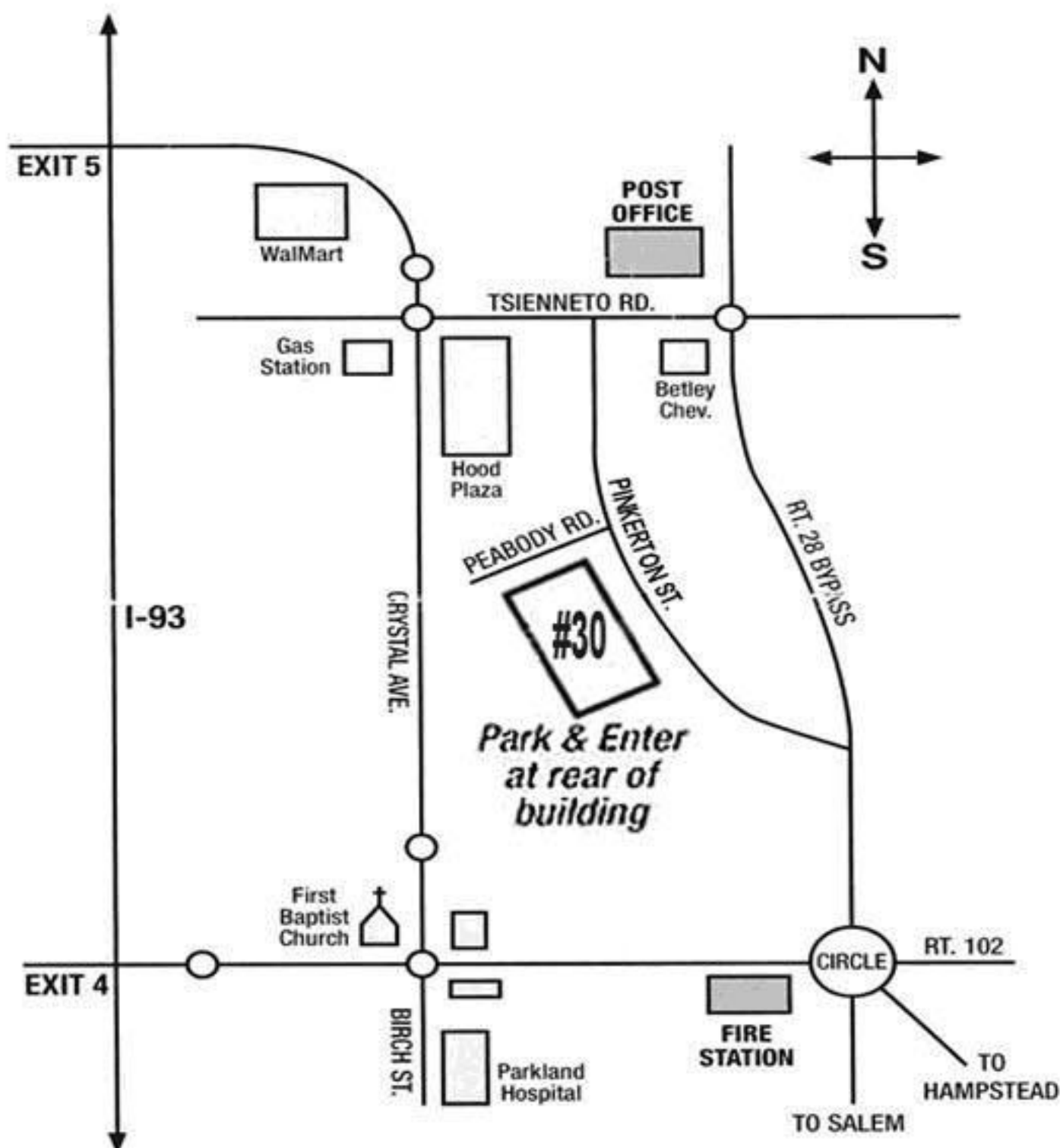
- This Tooth/Teeth Require(s) Root Canal Therapy
 - Symptomatic Pre-Pros/Prophy-Endo
- This Tooth/Teeth Require(s) Retreatment
 - Existing Post
- This Tooth Requires Periapical Surgery
- Evaluate and Treat as Necessary
- Evaluate Only and Call Me

- Patient has Pain / Swelling / Sensitivity
- Tooth Started / Accessed / Instrumented
- Pre-Medication Required
- Questionable Prognosis
- Existing Crown/Bridge
 - Permanent Cement Temporary Cements
- Crown will be Replaced:
 - Yes No Maybe

- Post Space Required
- Place the Post / Core
- Perform Crown-lengthening if necessary

Additional Comments: _____

Directions To Office



Derry, NH Office