



Salmon Creek Endodontics

Practice Limited to Endodontics
14400 NE 20th Ave. Suite 100
Vancouver, WA 98686

Phone: 360.576.5066

info@salmonendo.com

Fax: 360.576.5059

www.salmonendo.com

Scott George, DMD

Matt Anderson, DMD

Patient Name _____ Phone _____

Referred By _____ Date _____

Insurance Subscriber _____ ID# _____

Insurance Company _____ DOB _____

Root Canal Treatment **Retreatment** **Apicoectomy**

Please Circle Tooth to be Evaluated / Treated

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments _____

Restore with Temp Composite Amalgam Post

Patient requests N2O Oral Sedation IV Sedation

Appointment Date _____ Time _____

Signature of Referring Doctor Date

PLEASE EMAIL / FAX COMPLETED REFERRAL TO OUR OFFICE



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