

# Arlington Alexandria Endodontics

ROOT CANAL SPECIALISTS  
**FERNANDO J MEZA DMD**  
**H VIVIAN LEE DDS**  
**LOKEN M PATEL DMD**

**Alexandria Office**  
 4660 Kenmore Ave. #700  
 Alexandria, VA 22304

**Arlington Office**  
 1635 N George Mason Dr. #410  
 Arlington, VA 22205

Tel: **703.370.1327**

Fax: **703.370.1907**

Today's Date

Patient's Name

Referred by Dr.

## Please Provide:

- |   |   |
|---|---|
| <input type="checkbox"/> Evaluation Only                              | <input type="checkbox"/> CBCT Scan              |
| <input type="checkbox"/> Root Canal Therapy                           | <input type="checkbox"/> Leave Post Space       |
| <input type="checkbox"/> Evaluation for Apical Surgery or Retreatment | <input type="checkbox"/> Call after examination |

## Please Circle Tooth to be Treated

	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																

## Referred Due To:

- |   |                                 |
|---|---------------------------------|
| <input type="checkbox"/> Pain                   | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Radiographic Findings  |                                 |
| <input type="checkbox"/> Carious Pulp Exposure  |                                 |
| <input type="checkbox"/> Swelling / Sinus Tract |                                 |

## Status of Tooth:

- |  |
|--|
| <input type="checkbox"/> Previously Completed Root Canal     |
| <input type="checkbox"/> Root Canal Started but not Finished |
| <input type="checkbox"/> Crown – Permanently Cemented        |
| <input type="checkbox"/> Crown – Temporarily Cemented        |

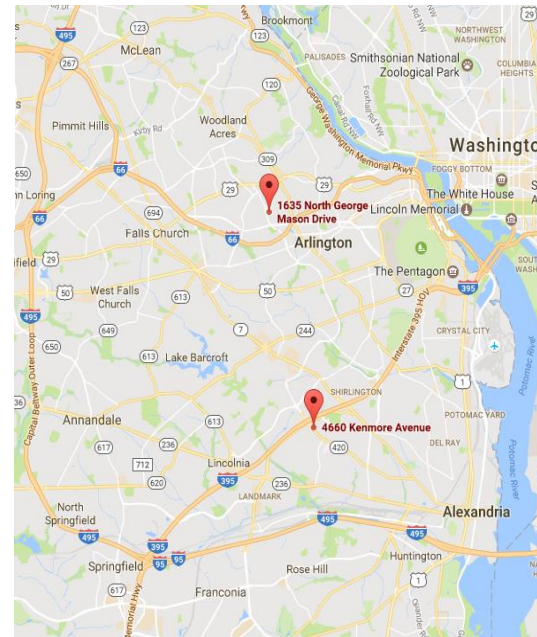
Remarks

[www.aarootcanal.com](http://www.aarootcanal.com)

## Patient Instructions:

- Please call the main office number and schedule an appointment as indicated by your referring dentist.
- Please bring this referral form and any x-ray provided by your dentist. If your dentist is sending radiographs by email, please mention this at the time of making the appointment.
- As a service to you, our practice participates with several insurance carriers and we will submit all necessary claim forms for you.
- Patients under 18 years of age must be accompanied by a parent or guardian to give written consent for treatment.
- New patient forms can be downloaded from our website at [www.aarootcanal.com](http://www.aarootcanal.com)
- If you are unable to keep your appointment, please give us the courtesy of 24 hours advance notice. Thank you for your consideration.

## Office Locations



### Arlington Office

Virginia Hospital Center  
 1635 North George Mason Drive  
 Suite 410  
 Arlington, VA 22205

Exit Glebe Road off I-66.

Parking is validated. Use on-site parking Building B (Gold).

### Alexandria Office

Alexandria Professional Center  
 4660 Kenmore Avenue  
 Suite 700  
 Alexandria, VA 22304

Exit Seminary Road off I-395.

Free parking on the ground level and garage level A.

**Arlington Alexandria Endodontics, PLLC**

Tel: 703.370.1327 Fax: 703.370.1907

Open M-F 8:00 am – 5:00 pm

Email: [admin@aarootcanal.com](mailto:admin@aarootcanal.com)

[www.aarootcanal.com](http://www.aarootcanal.com)

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Remarks

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