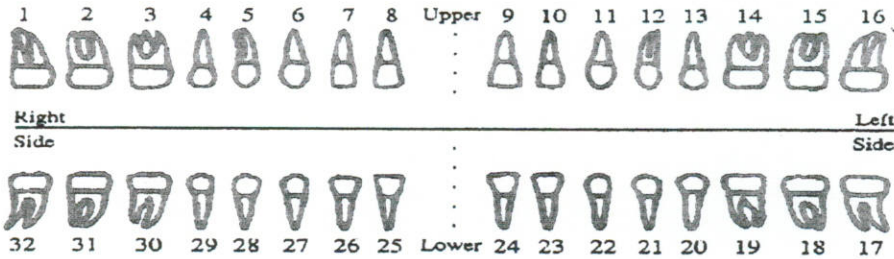


**Gail M. Davis, DDS, MS**  
**Practice Limited to Endodontics**

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 Tel. (301) 947-3400  
 www.davis-endo.com



Patient Name \_\_\_\_\_ Date \_\_\_\_\_



Referring Dr. \_\_\_\_\_

Phone \_\_\_\_\_

Please check as appropriate:

- Consultation only
- Endodontic therapy
- Retreatment
- Elective endodontic
- Pulp exposure has occurred
- Endodontic initiated
- Restoration temporary cemented
- Make post space

Remarks \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***Thank you for your confidence in us.***

- Please check box if you need more referral slips  
 (See Map Reverse Side)

