

WHITE BEAR LAKE
ENDODONTICS

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ENDODONTIC REFERRAL

Date _____

Patient _____

Dentist _____

Dentist Phone _____

Patient Referred for: _____

Evaluation & Treatment Consultation Only

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

- X-ray revealed pulp/periapical pathology
- Symptoms indicated endodontic problem
- Pain is of undefined origin
- Endodontic therapy has been initiated
- Please make post space

Remarks _____
