SIERRA DENTAL

Date _____

☐ **Dr. Kiarash Shabehpour**
DDS, DMD, MSc, Dip. Endo, FRCDC
Certified Specialist in Endodontics

☐ **Dr. Leslie Afable**
DDS, MS Endo, FRCDC
Certified Specialist in Endodontics

Patient's Name _____

DOB _____ Phone Number _____

Email Address _____

Medical Alerts/Allergies/Concerns _____

_____

Referring Dentist

Name _____ Clinic _____

Email _____ Phone _____

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Preferred Restoration:

- ☐ Temporary Restoration
- ☐ Final Restoration
- ☐ Leave Space for Post
- ☐ Post and Core Build Up

Radiographs Being Sent:

- ☐ Panoramic
- ☐ CBCT
- ☐ PA
- ☐ Bitewing

*Images may be repeated if needed

Internal Referral to additional Specialist(s) if recommended: ☐ Yes ☐ No

Comments:

403-297-9600
info@sierradental.ca