



GREAT NORTHERN ENDODONTICS^{PLLC}

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Patient Name: _____ Date: _____

Patient Phone#: _____ Date of Birth: _____

Referring Doctor: _____

Please call patient

Patient will call office

Appointment date and time: _____

Please circle any/all teeth that apply:

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

Consultation Only

Possible Fracture

RCT

Tooth Accessed

ReTx & Original Tx Date _____

Resorption/Repair

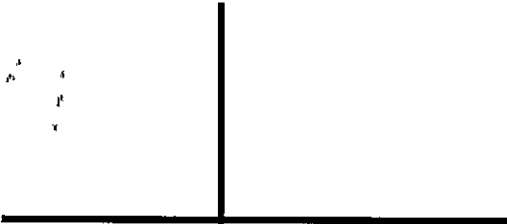
Recent Restoration in Area

Calcification/Obstruction

Existing Crown & Original Date _____

Comments: _____

Thank you for placing your trust in our office by sending your referrals our way. Please contact our office with any additional comments, questions or concerns.



RIMROCK ROAD



POLY DRIVE

N

BILLINGS MT OFFICE

Billings OB/GYN



ZIMMERMAN TRAIL

Ace Hardware

Christian Bros.

Walgreen Drug



GRAND AVENUE

32ND ST W

