RCT ENDODONTICS, LLC

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Introducing Patient: _____

Requesting: ❑ Evaluation ❑ Root Canal ❑ Retreatment/Apico

Tooth #(s): _____

Additional Comments: _____

_____

❑ Prepare Post Space ❑ CBCT Requested

❑ Please Send Additional Referral Pads to Our Practice

Kindest Regards:

Office/Dr. Name: _____

Tel.: _____ Referred Patient on: _____

Email: _____

All reports will be emailed unless otherwise specified.

Patient's Appointment:

Appt. Date: _____ Appt. Time: _____

❑ SILVER SPRING: (Saturday Appts. Avail.)	804 Pershing Drive, Ste. 102, Silver Spring, MD 20910 Ph.: 301-562-9455
❑ BOWIE:	3060 Mitchellville Road, Ste. 108, Bowie, MD 20716 Ph.: 301-218-7711
❑ LAUREL: (Saturday Appts. Avail.)	9889 Brewers Court, Laurel, MD 20723 Ph.: 240-360-2412
❑ NORTH POTOMAC:	11906 Darnestown Road, Ste. G, North Potomac, MD 20878 Ph.: 301-947-3400
❑ WASHINGTON, D.C.:	300 M Street SE, Ste. 410, Washington, DC 20003 Ph.: 202-701-1916

specialist member

Same Day Emergencies Welcome

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