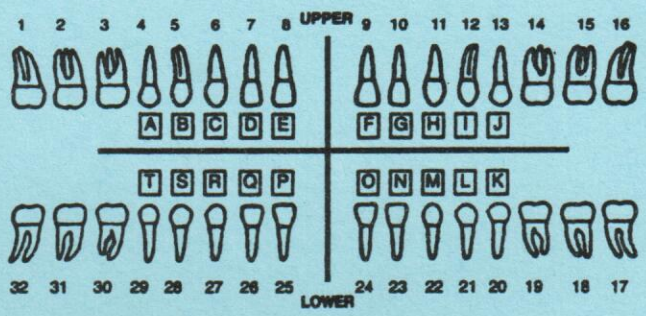
PATIENT NAME: _____ DATE: _____

REFERRING DOCTOR: _____



FOR ENDODONTIC CONSIDERATION OF TOOTH/TEETH #(S): _____

POST SPACE REQUESTED? YES_____ NO_____

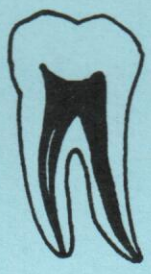
REMARKS:

GARDEN CITY ENDODONTICS, PLLC

Practice Limited to Endodontics

www.gardencityendo.com

ERIC W. BREMER, DDS
JAMES S. ATKINSON, DDS
DAVID P. JACOBSON, DDS
JAE Y. OH, DDS



601 Franklin Avenue
Suite 210
Garden City, NY 11530
Tel.: (516) 739-7668
Fax: (516) 739-7670