Bijan Pourjamasb, D.D.S., M.S.D., INC.
Practice Limited to Microscopic Endodontics

Microsurgical Endodontics

SPECIALIST MEMBER

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Irvine, CA 92618
Tel 949-727-1753
Fax 949-727-1754

DATE _____

(Please ask patient to bring this form to their consultation)

INTRODUCING _____

REFERRED BY DR. _____

☐ **CONSULTATION:** ☐ **CALL BEFORE TREATMENT**

☐ **TREATMENT:** ☐ **TREAT AS NEEDED**

☐ **PLEASE PERFORM POST SPACE**

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

REMARKS _____

Patient's Appointment:

Day _____ Date _____ Time _____