DR. ROBERT MACDONALD
B.Sc.,D.D.S.,M.Sc.
CERTIFIED SPECIALIST
#107-1899 WILLINGDON AVENUE
BURNABY, BC V5C 5T1

Office: 604-**299-1661**
Fax: 604-**299-1671**
Email: endo@shawbiz.ca

Date: _____

Introducing: _____

Tooth # _____ Phone # _____

Appointment Date: _____

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
				Right								Left				
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

- ☐ consultation only
- ☐ endodontic treatment
- ☐ retreatment (please send PA)
- ☐ post space
- ☐ close access with temporary
- ☐ close access with composite

Remarks _____

_____

_____

_____

_____

_____

_____

_____

- PATIENT INFORMATION -
Payment is expected at the time of the visit
UNLESS other arrangments have been made.

Signed - Dr. _____

Telephone No. _____

(SEE OVER - MAP)