Olive endodontics

Dr. Chae, Youngsook

Patient's name: _____ DOB: ___/___/____

Dental insurance: _____

Referred by: _____ Date: ___/___/____

Referring office phone: (____) _____-_____ ☐ need a new referral pad

Please indicate tooth/teeth.

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

Reason for referral:

☐ **Consult only** ☐ **Root canal treatment** ☐ **Re-treatment**

☐ **Microsurgery** ☐ **Post-space preparation**

Additional details:

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Our office faces **Walter Johnson Drive**, in **Building 1** inside the North Lake Professional Park.

Mon-Thu 9AM - 5PM
Fri 9AM - 4PM

19536 Doctors Drive, Germantown, MD 20874
Phone: 240.690.2112 • Fax: 240.690.2113
email: info@oliveendo.com • www.oliveendo.com