

ALLIANCE

ENDODONTICS

Dr. Alex Brown, DDS, MSc, FRCD(C)

Email: drbrown@allianceendodontics.ca
 Website: www.allianceendodontics.ca

Phone: 780.569.0255

Fax: 780.569.0297

60 Green Grove Drive, Suite #205 St Albert, AB T8N 5H6

Patient's Name _____

Date of Birth (D/M/Y) _____ **M/F**

Parent / Guardian Name _____

Phone # (h) _____ **(w)** _____ **(c)** _____

Address _____

City _____ **Postal Code** _____

1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8

Consult Treatment Retreatment/Surgery

History of: Trauma Perforation
 Endodontic treatment Resorption

Please indicate a restorative directive.

Temporary filling Post and core build-up
 Permanent core build-up Leave post space

Remarks: _____

Referred by: Dr _____

Date: _____ **Office phone:** _____

- Please call patient Patient will call
 Radiographs (sent in mail) Please take radiograph
 Radiographs (emailed: drbrown@allianceendodontics.ca)

Please see www.allianceendodontics.ca to complete medical history form and for further information.

Appointment Date _____ **Time** _____

