Glen B. Mitchell Endodontics
900 Glades Rd #3a
Boca Raton, FL 33431
Phone: 561.368.3636

Patient Name: _____

Tooth/Teeth #'s: _____

Please initial the following paragraphs, and sign where indicated,
acknowledging your understanding & receipt of information:

☐ 1. I understand my endodontic treatment is complete and an appointment needs to be made with my general dentist to permanently restore my tooth (teeth), within the next 30 days.

☐ .2. It is normal to experience sensitivity for up to 1 week following treatment. I will inform the office if l have increasing sensitivity.

☐ 3. I understand it is my responsibility to call our office in one year for a "Recall" appointment.

Patient (Guardian) Signature: _____

Date: _____

Employee Initials: _____