EASTERN IOWA ENDODONTICS

Derek T. Peek DDS, MS **Thomas L. Peek DDS, MS**

2929 Center Point Rd. NE
Cedar Rapids, IA 52402
www.eiendo.com

phone: 319-382-8002
fax: 319-382-8111

____
PATIENT NAME **DOB**

____
REFERRING DENTIST

____
PATIENT PHONE NUMBER

____
DENTIST PHONE NUMBER

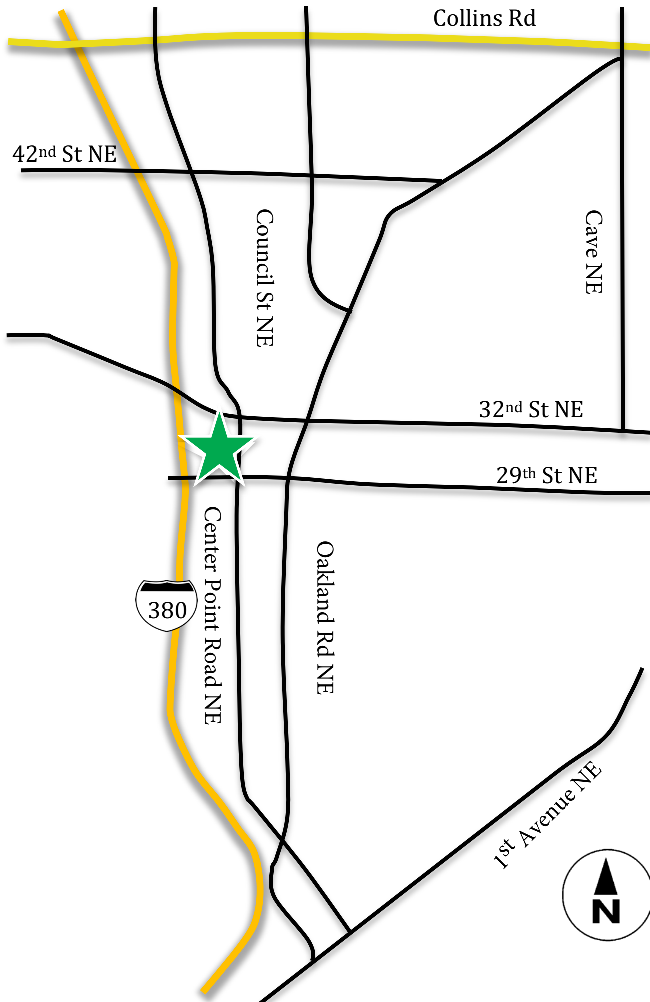
____
INSURANCE INFORMATION

____
APPOINTMENT DATE **TIME**

2	3	4	5	6	7	8	9	10	11	12	13	14	15
31	30	29	28	27	26	25	24	23	22	21	20	19	18

TOOTH # __________ ☐ ROOT CANAL ☐ RETREATMENT ☐ CONSULT ONLY

COMMENTS: ______________________________



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REMEMBER:

- Write down and bring medication list
- Bring insurance card
- Minors must be accompanied by a parent or guardian
- **Payment is due at time of service**