



JOHN W. PAWLUK, DDS
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 WWW.ENDO-ILLINOIS.COM

PATIENT:

NAME: _____
 DATE OF BIRTH: _____
 PHONE: _____
 EMAIL: _____

REFERRING DOCTOR:

NAME: _____
 PHONE: _____
 EMAIL: _____
 TODAY'S DATE: _____

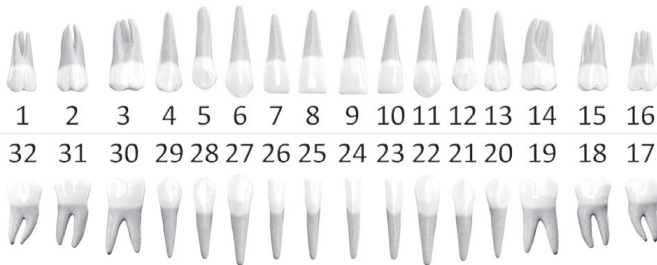
DESIRED TREATMENT:

- | | |
|--|---|
| <input type="checkbox"/> ENDODONTIC CONSULTATION | <input type="checkbox"/> DENTAL IMPLANT |
| <input type="checkbox"/> ROOT CANAL | <input type="checkbox"/> CALL PRIOR TO TREATMENT |
| <input type="checkbox"/> RETREATMENT | <input type="checkbox"/> _____ |
| <input type="checkbox"/> ENDODONTIC SURGERY | |
| <input type="checkbox"/> POST SPACE DESIRED | NEW CROWN PLANNED: <input type="checkbox"/> YES <input type="checkbox"/> NO |

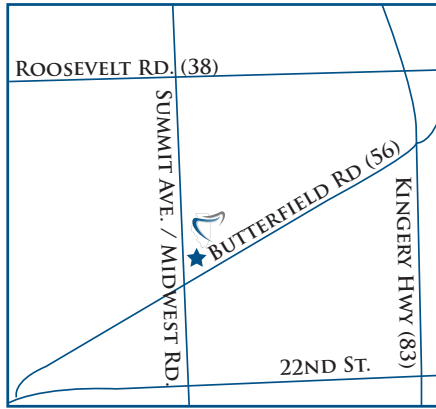
HISTORY:

- | | |
|---|---|
| <input type="checkbox"/> PAIN | <input type="checkbox"/> FRACTURE/CRACK |
| <input type="checkbox"/> SWELLING | <input type="checkbox"/> TRAUMA |
| <input type="checkbox"/> BITE SENSITIVITY | <input type="checkbox"/> ROOT CANAL INITIATED |
| <input type="checkbox"/> PULP EXPOSURE | <input type="checkbox"/> _____ |

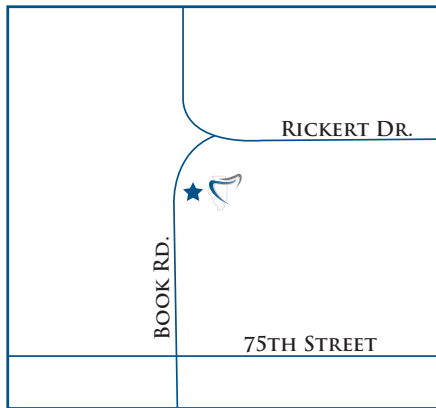
AREAS OF CONCERN:



NOTES:



OAKBROOK TERRACE
GALLERY BUILDING
1 SOUTH 443 SUMMIT AVE
SUITE 306
OAKBROOK TERRACE, IL 60181



NAPERVILLE
1891 BAY SCOTT CIRCLE
SUITE 105
NAPERVILLE, IL 60540



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