ENDODONTIC ASSOCIATES OF ILLINOIS

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PATIENT:

NAME: _____

DATE OF BIRTH: _____

PHONE: _____

EMAIL: _____

REFERRING DOCTOR:

NAME: _____

PHONE: _____

EMAIL: _____

TODAY'S DATE: _____

DESIRED TREATMENT:

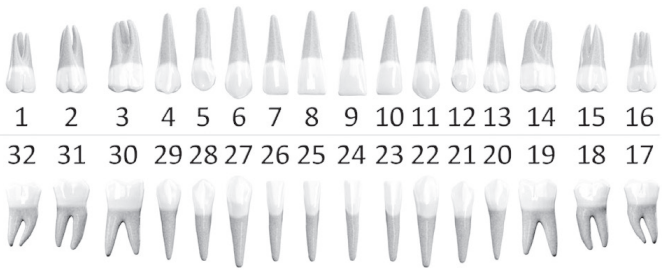
- ☐ ENDODONTIC CONSULTATION
- ☐ ROOT CANAL
- ☐ RETREATMENT
- ☐ ENDODONTIC SURGERY
- ☐ POST SPACE DESIRED
- ☐ DENTAL IMPLANT
- ☐ CALL PRIOR TO TREATMENT
- ☐ _____

NEW CROWN PLANNED: ☐ YES ☐ NO

HISTORY:

- ☐ PAIN
- ☐ SWELLING
- ☐ BITE SENSITIVITY
- ☐ PULP EXPOSURE
- ☐ FRACTURE/CRACK
- ☐ TRAUMA
- ☐ ROOT CANAL INITIATED
- ☐ _____

AREAS OF CONCERN:



NOTES:

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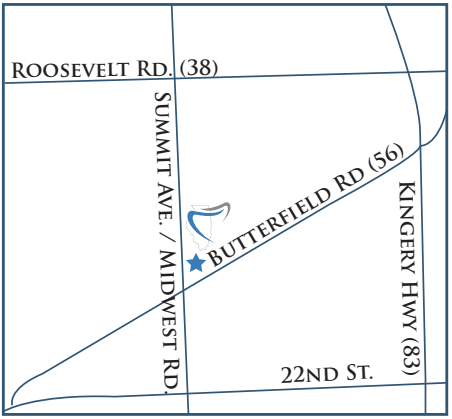
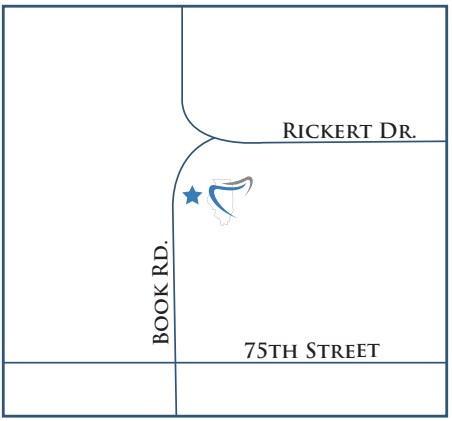
■ END OF REFERRAL SHEETS, PLEASE REORDER



Oakbrook Terrace

Gallery Building
1 South 443 Summit Ave
Suite 306
Oakbrook Terrace, IL 60181



Naperville

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