

OAKVILLE
ENDODONTICS
Est. MMXXV

Introducing:

Given Name:

Family Name:

M	D	Y

Date:

[illegible]

Tel:

Email:

M	D	Y

Appointment Date:

Time:

○ AM

○ PM

Purpose of Consultation:

- ☐ Endodontic Consult & Treat As Necessary
- ☐ Endodontic Re-treatment
- ☐ Endodontic Surgery
- ☐ Dental Trauma
- ☐ Tooth Previously Opened
- ☐ Please Call After Consult / Prior to Treatment
- ☐ Post Space
- ☐ Other:

R	18	17	16	15	14	13	12	11		21	22	23	24	25	26	27	28	L
	48	47	46	45	44	43	42	41		31	32	33	34	35	36	37	38	

Comments:

**Please email radiographs to reception@oakvilleendo.ca*

Referred By:



OAKVILLE ENDODONTICS

Est. MMXXV

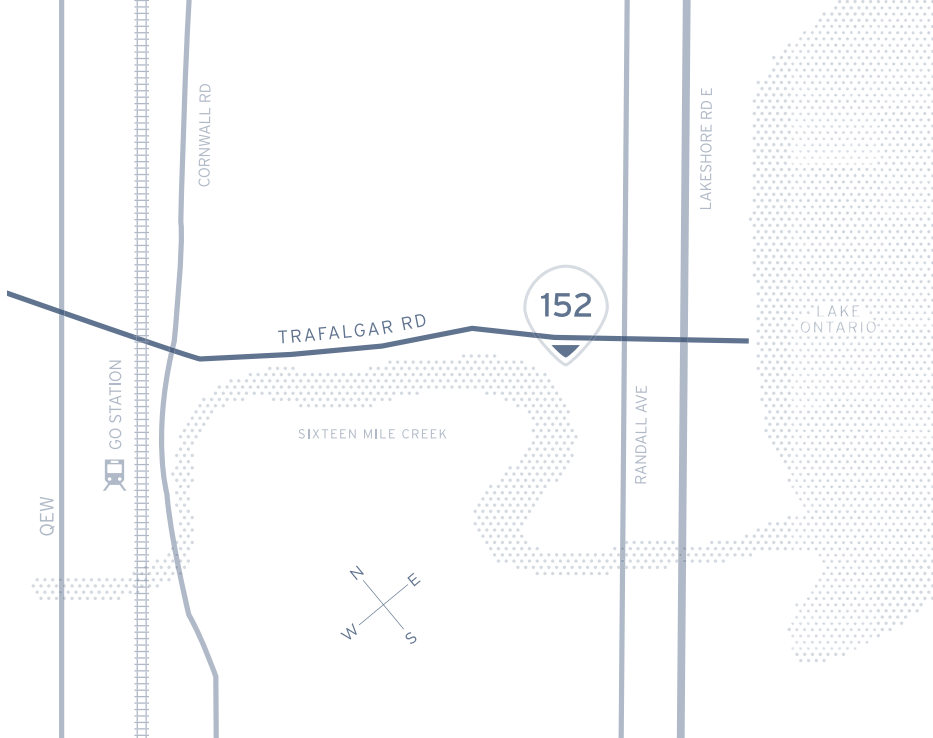
DR. HARKARAN BAJWA
M.D.S. CERT. ENDO.

T.905.338.2233
F.905.337.2234

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OAKVILLE ON L6J 3G6

RECEPTION@OAKVILLEENDO.CA

OAKVILLEENDO.CA



Please Bring to Your Appointment:

- ☐ Any x-rays given to you by your dentist
- ☐ List of any medications you are currently taking
- ☐ Dental insurance information

* We do not take assignment. Payment may be made by Visa, Mastercard & Interact.