Pawliuk
FAMILY DENTISTRY

Dr. Jonathon Pawliuk
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REQUEST FOR MEDICAL INFORMATION

Date: _____

To: _____

Address: _____

I would like further information concerning the medical status of the following patient in order to plan the appropriate dental care. Thank you.

Patient: _____ Phone: _____

Address: _____

Date of Birth: _____

Anticipated Dental Care: _____

_____

_____

_____

Dentist Signature

Medical Findings and Recommendations: _____

_____

_____

_____ _____

Physician Signature Date

Permission is hereby granted for the release of information concerning my health or above named dependant's health to the above named dentist.

_____ _____

Patient Signature Date