Silicon Valley Endodontics and Microsurgery
Jason Kung, DDS, MS
Practice Limited to Endodontics

1298 Kifer Road, Ste 502 * Sunnyvale, CA 94086 * Tel/Text: 669.234.2354

siliconvalleyendo@gmail.com
www.svendodontics.com

Patient _____ **Patient Phone** _____

Area of Concern: **Patient DOB** _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Reason for Referral

O Consultation only
O Evaluate and treat as indicated
O Patient has pain, swelling, or sensitivity
O Periapical Radiolucency
O Pulp Exposure
O RCT needed for proper restoration
O Evaluation for endo surgery (apico) or retreatment
O Tooth opened (accessed), RCT initiated

Miscellaneous

O Crown/bridge is cemented
  O Temporarily
  O Permanently
O Please send referral forms
O Call/text me about case

X-Ray/Radiographs

O Are being emailed to: siliconvalleyendo@gmail.com
O Given to patient

Special Instructions, Restorative Treatment Plan

_____

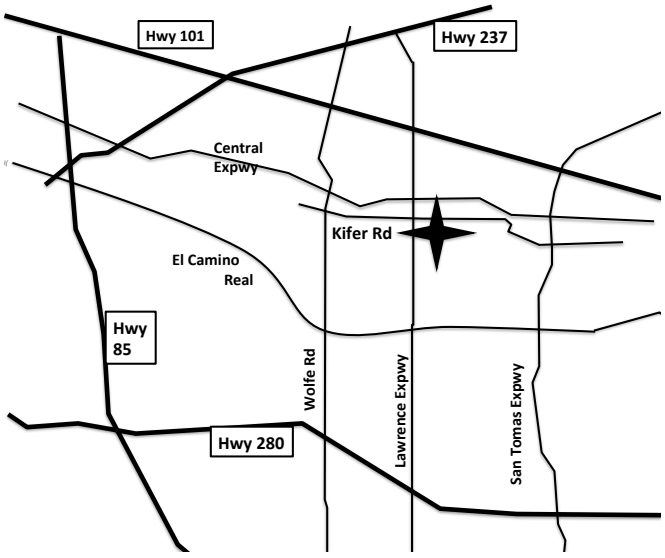
_____

Restorative Instructions

O Place post and build-up
O Place core buildup only – no post
O Leave post space
O Place cotton and cavit I will restore

Referred by _____ **Date** _____

Phone_____ **Email** _____



Dear Patient,

Our specialty office would like to welcome you. For the appointment, please bring

- This referral slip
- Any related x-ray images, and medical/dental records
- Insurance information/documentation if applicable. We will confirm your dental beneifts prior and notify you of your estimated co-pay.

Your Appointment Date _____ Time _____

When the treatment is completed, we will refer you back to your referring dentist.

If you will not be able to keep your appointment, please give us a minimum of 48 hours notice.