HUANG ENDODONTICS

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PATIENT REFERRAL FORM

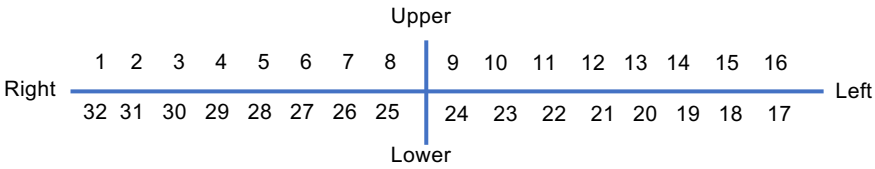
Introducing: _____ Date: / /

Phone: _____

Referred by Dr. _____

Office Phone: _____ Office E-mail: _____

Please circle the tooth or teeth to be evaluated :



Reason for referral:

[ ] Pain or swelling
[ ] Radiographic findings
[ ] Deep caries
[ ] History of trauma
[ ] Root canal needed for restoration
[ ] Other: _____

Requested treatment :

[ ] Root canal treatment
[ ] Retreatment
[ ] Apicoectomy surgery
[ ] Evaluation only
[ ] Leave post space
[ ] Place post (as needed) and buildup
[ ] Place orifice barrier
[ ] Please call to discuss

Remark: _____

_____

_____

Please Fax this form to (209) 529-0058, or Email it to modestoendo@gmail.com

specialist member

Please visit us at www.huangendo.com

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