



**Yujie Huang D.D.S. Ph.D.**  
**Yung M. Kang D.D.S. D.Sc.D.**  
***Certified Specialists in Endodontics***

4101 Tully Road, Suite 602 Modesto, CA 95356  
E-mail: [modestoendo@gmail.com](mailto:modestoendo@gmail.com) Phone: (209)-529-1698 Fax: (209)-529-0058

## PATIENT REFERRAL FORM

Introducing: \_\_\_\_\_

Date:     /     /

Phone: \_\_\_\_\_

Referred by Dr. \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office E-mail: \_\_\_\_\_

**Please circle the tooth or teeth to be evaluated :**

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

Reason for referral:

- |                                                |                                                            |
|------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Pain or swelling      | <input type="checkbox"/> History of trauma                 |
| <input type="checkbox"/> Radiographic findings | <input type="checkbox"/> Root canal needed for restoration |
| <input type="checkbox"/> Deep caries           | <input type="checkbox"/> Other: _____                      |

Requested treatment :

- |                                               |                                                             |
|-----------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Root canal treatment | <input type="checkbox"/> Leave post space                   |
| <input type="checkbox"/> Retreatment          | <input type="checkbox"/> Place post (as needed) and buildup |
| <input type="checkbox"/> Apicoectomy surgery  | <input type="checkbox"/> Place orifice barrier              |
| <input type="checkbox"/> Evaluation only      | <input type="checkbox"/> Please call to discuss             |

Remark: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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



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