



— OAK HILLS —  
ENDODONTICS

**Patient Referral**

Patient's Name: \_\_\_\_\_  
Patient's Phone: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
Patient Zip Code: \_\_\_\_\_ Dental Insurance: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
Referred by Dr. \_\_\_\_\_

**Teeth for evaluation:**

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

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Restore tooth with the following:  Permanent Restoration  Temporary Restoration

Would you like our office to call the patient to schedule an appointment?  Yes  No

Date of appointment: \_\_\_\_\_ Time of appointment: \_\_\_\_\_

**Please fax a copy of this referral to 210.342.2443. Thank you.**

