



OAK HILLS
ENDODONTICS

Patient Referral

Patient Name: _____
Patient Phone: _____ Patient DOB: _____
Patient Zip Code: _____ Dental Insurance: _____
Member ID: _____ Insurance Phone: _____
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.



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