



— OAK HILLS —
ENDODONTICS

Patient Referral

Date: _____

Introducing _____ Telephone: _____

Referred by Dr. _____ Telephone: _____

Tooth for evaluation/treatment: _____

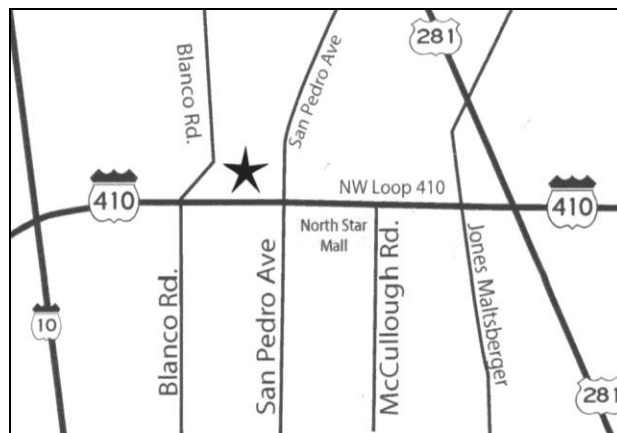
Status of tooth and recommendations: _____

Please restore tooth with the following: Amalgam Cavit Composite

Would you like for 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.



**601 NW Loop 410, Suite 455
San Antonio, Texas 78216
210.342.2444**