



## Doctor Referral Form

2510 Stevens Creek Blvd.  
San Jose, CA 95128  
(408) 999-0444

Referred By Doctor:

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Referred Patient:

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Parent/Guardian:

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Birthdate:

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Address:

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Telephone:

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REASON FOR REFERRAL:  Consultation  Treatment

Please provide appropriate details of problem (i.e. urgency, areas of concern):

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RELEVANT HISTORY (Indicate any special factors – either dental or medical – such as known allergies and specific medical problems relevant to diagnosis and treatment.):

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Call referring doctor before treatment:  Yes  No

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Radiographs:  sent with patient  mailed/transmitted  attached  none available

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Please provide written report.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_