10363 Torre Ave #E; Cupertino, CA 95014

T: (408) 252-3602 Fax (408) 252-3603

Referral Date: _____

Referring Doctor: _____

Referring Dr. Phone #: _____

Patient Name: _____

Patient Phone #: _____

❑ Comprehensive Treatment

❑ Limited Treatment: Tooth Number(s): _____

- ❑ Crown(s)
- ❑ Implant(s)
- ❑ Denture(s)
- ❑ Cosmetic/Veneer(s)
- ❑ Other _____

❑ Radiographs: Date Taken: _____

- ❑ With patient ❑ Will send separately
- ❑ Periapical(s) ❑ Bitewing(s) ❑ FMX ❑ Panoramic ❑ None provided

❑ Patient will return to referring dentist's office for follow up and maintenance care.

Additional Comments:

Referring Dr. Signature _____

Original copy: Please send/fax copy to Dr. Gong's office

Copy: Referring Doctor's Office