



William Y. Chen, D.D.S., Inc.
 Dale Jung, D.D.S., Inc.
 Jeffrey Kawilarang, D.D.S., Inc.



Date _____

Patient's Name _____

Tooth # _____

Please evaluate and perform the following:

- Root Canal Treatment
- Root Canal Retreatment
- Endodontic Surgery
- Consultation and diagnosis
- CBCT Scan
- Internal Bleaching
- Prepare Post Space
- Provide Post / Core Buildup (circle one)
- Repair Crown: Composite / Amalgam (circle one)

	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	

Email final report: _____
 email address _____

Other findings or recommendations: _____

Referring DDS or DMD

Please check which office you would like your patient to be seen at:

Sunny Hills Endodontics

220 W. Laguna Rd, #3
 Fullerton, CA 92835

Phone: (714) 738-6651
 Fax: (714) 738-6653
 Email: office@sunnyhillsendo.com
 www.sunnyhillsendo.com

Huntington Beach Endodontics

17931 Beach Blvd, Ste 200
 Huntington Beach, CA 92647

Phone: (714) 847-8488
 Fax: (714) 847-1582
 Email: office@hbendo.com
 www.hbendo.com

Please bring this referral slip with you to your appointment. Thank you.



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HUNTINGTON BEACH ENDODONTICS



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