# Endodontic Referral

Date:_____

Referring Doctor:_____

Patient Name:_____

Patient Phone:_____

Patient Email:_____

**Tooth#:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |

**Endodontic Services Requested:**

☐Endodontic Consultation Only

☐Endodontic Consult and Treat As Necessary

☐Endodontic Surgery

☐Please Call After Consult/Prior to Treatment

☐Other:_____

**Special Instructions:**

_____

_____


VALLEY GREEN ENDODONTICS

**HOWARD LIANG, DDS**

PRACTICE LIMITED TO ENDODONTICS

2707 E VALLEY BLVD SUITE 202
WEST COVINA, CA 91792
Phone: 626-965-6898
Fax: 626-965-6896
www.ValleyGreenEndodontics.com


**You can log onto our secure website and conveniently complete Patient Registration, Medical History and Pain History online prior to the appointment. Please contact our office for an ID and Password.**

**Requested Coronal Endo:**

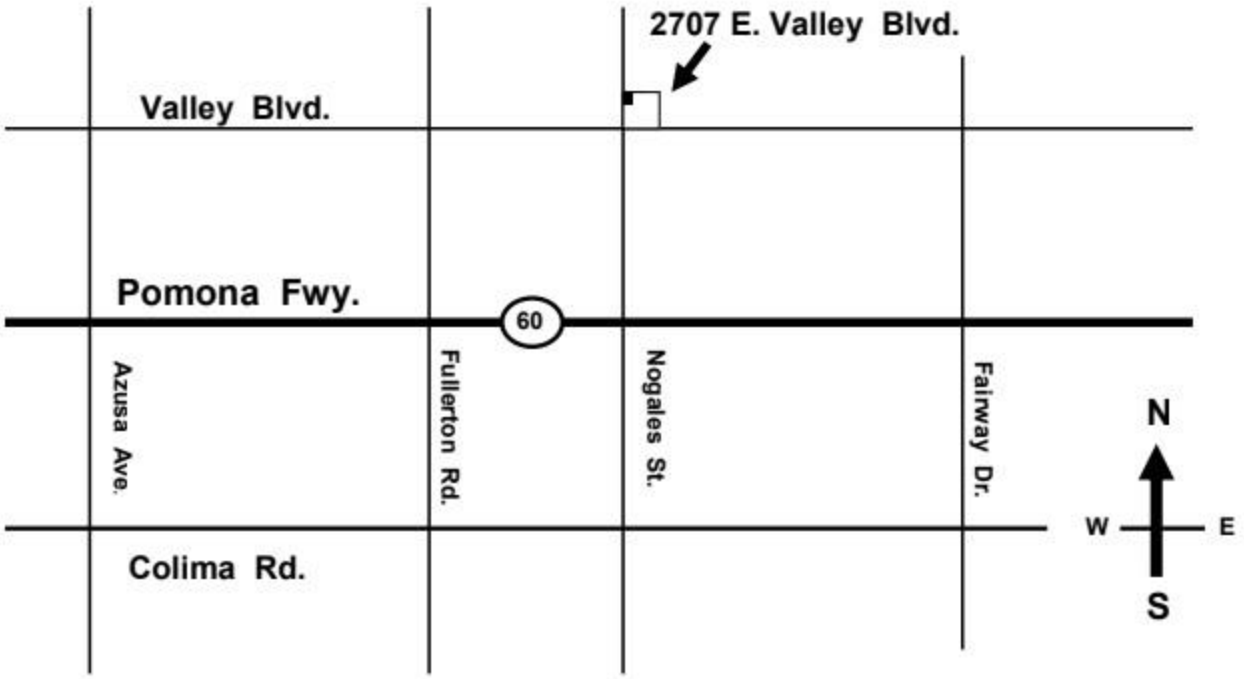
☐Temporary Access Restoration

☐Permanent Build-up

☐Post & Core Build-up

☐Post Space

☐Other:_____




Conveniently located on the corner of Nogales St. and Valley Blvd.

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