

Lee Huynh, DDS & Toan Van, DDS

Patient Name: _____ Phone: _____

Referring Office: _____ Phone: _____

Member ID: _____ Agency: _____

NEXT appt in your office: _____

Reason for Referral:

- Oral Inflammatory Disease (Periodontal) Sleep-Related Breathing Disorder
 Cosmetic Dentistry General Evaluation
 Restorative Dentistry _____
 Extractions: _____

Chief Concern: _____

Radiographs

- Emailed Sent with patient None available Please take

Remarks or Special Instructions: _____

Please consult my patient,

Referring Doctor's name

Referring Doctor's Signature

Date

Please fax or email directly to
832.378.7870 (office) 281.903.7488 (fax) patientcare@havendentistrytx.com

WE ARE LOCATED AT
18502 West Belfort Street, Suite 112, Richmond, TX 77407

