HAVEN DENTISTRY

PATIENT REFERRAL FORM

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 Bellfort Street, Suite 112, Richmond, TX 77407