



Practice Limited to Endodontics
Michael Do, D.D.S.
www.sandiegoendodontist.com

Referral Card

PLEASE CHECK:

- | | |
|---|---|
| <input type="checkbox"/> Consultation / Diagnosis | <input type="checkbox"/> CBCT SCAN |
| <input type="checkbox"/> Endodontic Treatment | <input type="checkbox"/> Endodontic Retreatment |
| <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Internal Bleaching |
| <input type="checkbox"/> Other _____ | |

PLEASE CIRCLE:

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

Patient

Phone

Referred By

Date

La Jolla Dental Specialty Group

5830 Oberlin Dr. Suite 103
San Diego, CA 92121
Phone: (858) 546-1802
Fax: (858) 546-1242

**PLEASE BRING THIS REFERRAL
SLIP AS WELL AS YOUR INSURANCE
INFORMATION TO YOUR APPOINTMENT.**

(map on back)

Please give 24 hours notice in case of cancellation.
Please arrive 20 minutes early to fill out paperwork.

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