VALLEY VIEW DENTAL

A FAMILY PRACTICE THAT TREATS YOU LIKE FAMILY ™

Referral Form

Clarence S. Tang, D.D.S., M.D.
Oral Surgeon

Phil Meehan, D.D.S., OMFS
Oral Surgeon

Referring Dentist: _____ Referring to: _____

Patient's name: _____
Last First Middle

Date of most recent panoramic radiograph _____

❑ Radiograph given to patient ❑ Radiograph emailed (frontdesk@vvdental.com)

			A	B	C	D	E	F	G	H	I	J			
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
			T	S	R	Q	P	O	N	M	L	K			

REASON FOR REFERRAL:

❑ Consultation Re:

_____

_____

❑ Treatment (as requested):

_____

_____

Relevant History:

_____

_____

Comments:

_____

_____

❑ An appointment has been made.

_____

❑ Post-referral maintenance ❑ By specialist ❑ To be discussed

Referring Dentist Signature: _____ Date: _____