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Patient name: _____

Phone: _____

Referred by Dr. _____ Date: _____

Tooth # _____ Appt date _____ Time _____

Reason for Referral:

- Consultation only
- Endodontic therapy
- Endodontic surgery
- Retreatment

Restorative Instructions:

- Place post and build-up
- Place build-up
- Leave post space
- Place temporary restoration

Pertinent history:

- Previous root canal
- Pain and/or swelling
- PA lesion
- Pulp exposure
- RCT required for restoration

Treatment performed:

- Root canal initiated
- Recent restoration
- Antibiotics prescribed
- Pain medication prescribed

Radiographs:

- Sent by email/mail
- Given to patient
- To be taken

Sedation:

- Nitrous oxide
- Oral conscious sedation

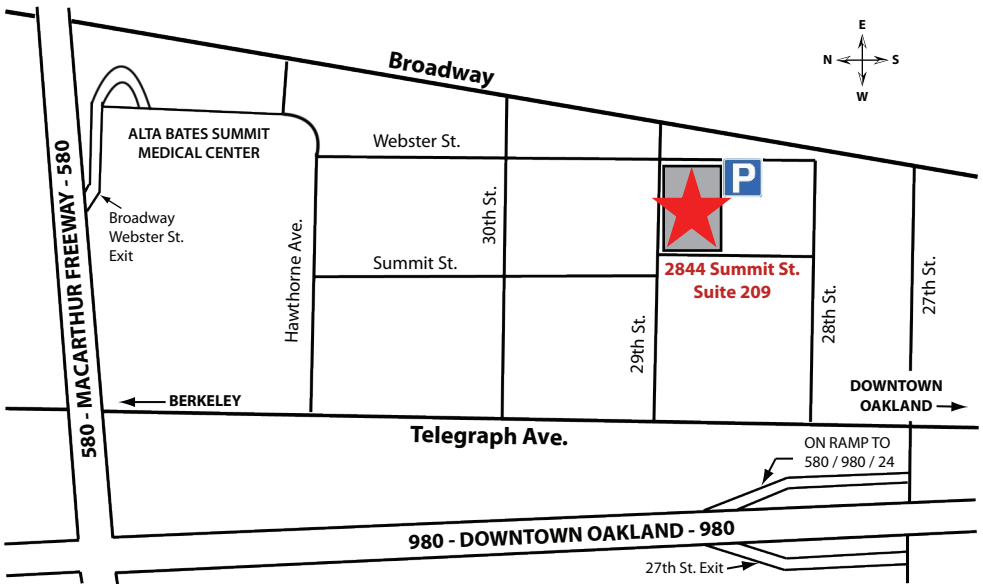
Comments _____

Please give 48 hours notice if you are unable to keep your appointment.
 See reverse for Maps, Directions and Parking.

Please bring with you the following items to expedite your appointment:

- 1) This referral form
- 2) Any x-rays provided by your dentist
- 3) All insurance information

We are located on the corner of Summit and 29th Streets. **Free parking** is available for patients adjacent to the building. Entrance to the parking lot is on the back side on Webster St. Elevator accessibility is available only at the front entrance on Summit St.



Bay Endodontics - Root Canal Specialists
2844 Summit St., Suite 209
Oakland, CA 94609