OCEAN ENDO

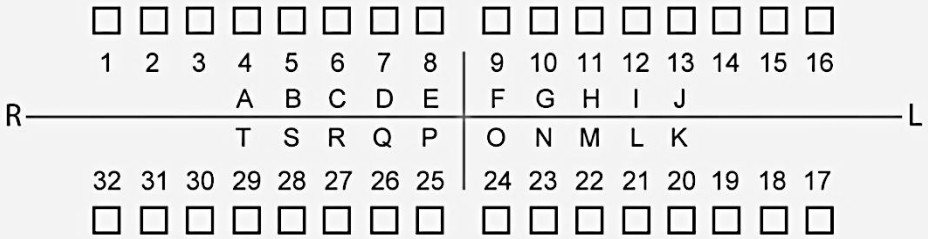
Kelly Kimiko Leong, DMD
Diplomate, American Board of Endodontics

Patient Name: _____ **DOB:** _____
Patient Phone Number: _____ **Call patient to schedule: Y / N**
Referring Doctor: _____ **Phone:** _____

Reason for Referral:

- ☐ Apicoectomy
- ☐ Botox for Bruxism
- ☐ CBCT
- ☐ Consultation Only
- ☐ Cracked Tooth Evaluation
- ☐ Internal Bleach
- ☐ Retreatment Root Canal
- ☐ Root Canal Therapy
- ☐ Resorption Evaluation
- ☐ Nitrous Oxide Sedation
- ☐ Oral Conscious Sedation

Tooth Number *(please indicate tooth)*: _____



Preferred Access Closure:

- ☐ Sponge & Cavit
- ☐ Orifice Barrier
- ☐ Build-up
- ☐ Post & Core
- ☐ Post Space
- ☐ Other: _____

Comments / Notes: _____

_____

_____

Date Sent: _____ **Signature:** _____

Please transmit PHI securely. By sending this form, you confirm the patient has consented to share information for treatment coordination.

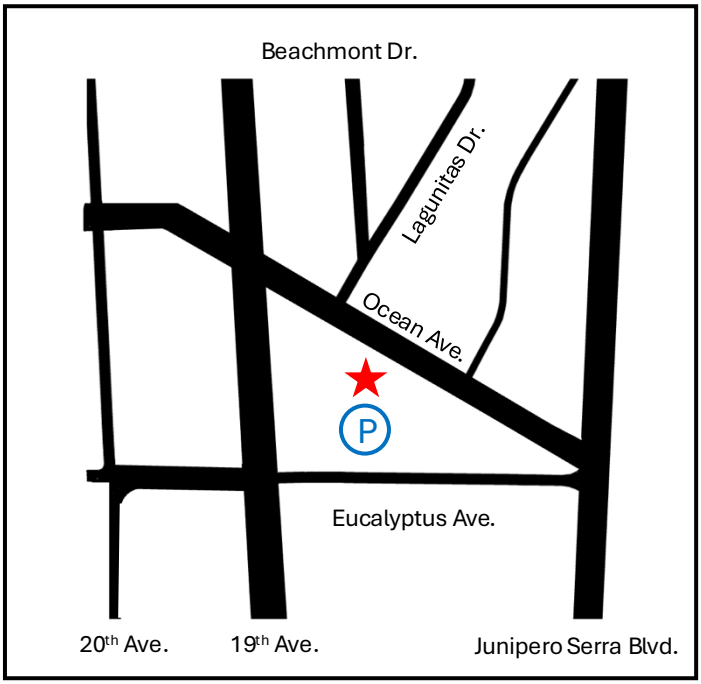
2645 Ocean Ave., Ste. 203, San Francisco, CA 94132
Ph: 415-741-3636 |Fax: 415-766-7032 |oceanendosf.com |info@oceanendosf.com

OCEAN ENDO

Kelly Kimiko Leong, DMD
Diplomate, American Board of Endodontics

To prepare for your dental appointment:

- Please bring this referral form
- Medical history information (including a list of current medications)
- Dental insurance information



There is a free patient parking lot through the archway at 2645 Ocean Avenue. Additionally, there is 2-hour metered parking along Ocean Avenue and non-metered parking along side streets.

QR code will route to our address:

2645 Ocean Ave., Ste. 203
San Francisco, CA 94132

Ph: 415-741-3636 | Fax: 415-766-7032 | oceanendosf.com | info@oceanendosf.com