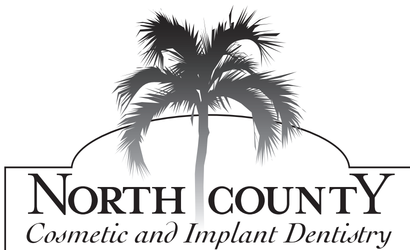

Referral Slip

Christopher Henninger, D.M.D. ♦ Craig R. Huenergardt, D.D.S.

1934 Via Centre • Suite A • Vista, CA 92081
Office: 760.940.2273
www.ultimatesmiles.com

Introducing ________________________ Today's Date __________

Referring Dr. ______________________ Office Phone __________

Please mark teeth or area to be treated:

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

REQUEST INFORMATION

__Consultation
__3rd Molars
__Extractions
__Dental Implants
__Bone Grafting
__Restoration Dentistry
__IV Sedation

__Surgical Exposure
__Gingival Graft
__Crown Lengthening
__Biopsy
__Special Needs
Behavior Management
__Panoramic X-ray
__Cone Beam CT Imaging

Reason for Scan: ____

Please indicate teeth or area on above chart for scan.

Other comments ____

Signature ____________________ Request call from Dr. __________