FAX REFERRAL

To: Jochen P. Pechak DDS MSD **Fax:** (408) 733-5720

From: _____ **Date:** _____

CC: _____ **Pages:** _____

☐ **Urgent** ☐ **Call to discuss** ☐ **Please Comment**

Introducing: _____ Referring Doctor _____

Home Phone _____
Work Phone _____
Cell Phone _____

Reason for Referral:

O Comprehensive Exam & Treatment
O Soft tiissue grafting
O Socket preservation
O Evaluation for Implants
O Crown lenghtening
O Other

Specific Concerns: _____
_____
_____

O Patient has radiographs

O Radiographs are being sent by email: GumsRusOffice@Gmail.com

O Radiographs are available for pick-up

O No current radiographs available

_____

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download this form and more at:

WEB: www.DrPechak.com