



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:

Comprehensive Exam & Treatment

Soft tissue grafting

Socket preservation

Evaluation for Implants

Crown lengthening

Other

Specific Concerns: _____

Patient has radiographs

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

Radiographs are available for pick-up

No current radiographs available

**500 South Murphy Avenue
Sunnyvale, CA 94086**

download this form and more at:

WEB: www.DrPechak.com

Office: (408) 738- 3423