

# Las Colinas Endodontics

Mercedes S. Dominguez, DDS, MS  
Specialist in Endodontics

## REFERRAL SHEETS

Date: \_\_\_\_\_

Referral is the Courtesy of: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SS#: \_\_\_\_\_

Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_

Employer: \_\_\_\_\_

Tooth # (s): \_\_\_\_\_ Area: \_\_\_\_\_

\_\_\_\_\_ Appointment has been made. \_\_\_\_\_ Patient will call. \_\_\_\_\_ Please call the patient.

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

Close Access with: Cotton/Cavit Build-up Composite

Place Post Leave Post Space

C o m m e n t s :

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7200 N Hwy 161, Ste 215, Irving, Texas 75039 Phone: 972.556.2100 Fax: 972.556-2112