KHANG T. LE, D.D.S.

The Waters at Creekside
2900 Bristol Street, D105
Costa Mesa, CA 92626
Phone: 714-668-1620
Fax: 714-668-1246
Email: scendodontics.le@gmail.com
Website: www.scendodontics.com

Referring Doctor ____

Practice Name ____

Address ____

____

Phone #:__________________________ Email:______________________

Patient's Name ____

Phone #:____

Appointment Date:______________________________ Time:__________

Tooth/Teeth#, or Region:______________________________

Reason for referral: (please checkmark below)

___ Endodontic Treatment ___ Endodontic **R**etreatment
___ Consultation only ___ CT Scan ___ Pano
___ Surgical Endodontic ___ Post Space ___ Post only
___ Buildup only ___ Post & Core Buildup
___ Other:____

Comments:____

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