

**JAMES A. COX, DDS
CRISTIAN MIRANDA, DDS**

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Referral For Services

Check one:

James A. Cox, DDS

Cristian Miranda, DDS

Date _____ Referring Doctor _____

Introducing _____

Patient Phone Number _____

Appointment Status:

Urgent

Call to Discuss

Call Patient to Schedule

Patient Scheduled on _____

Please evaluate for the following treatment:

Please indicate tooth number(s)/site:

	A	B	C	D	E	F	G	H	I	J							
Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Left
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
	T	S	R	Q	P	O	N	M	L	K							