PLEASE EMAIL TO: office@beyonddentaldurham

BEYOND DENTAL

Dr. Lei Cao
Dr. Sutasinee Liu

DATE: _____

NAME: _____ **D.O.B.** _____

REFERRING DOCTOR: _____

PATIENT PHONE: _____ **PATIENT EMAIL:** _____

REASON FOR REFERRAL

- ☐ GAG REFLEX
- ☐ NEEDLE PHOBIA
- ☐ DENTAL PHOBIA

SERVICE NEEDED

- ☐ IV SEDATION
- ☐ CONSULT
- ☐ IMPLANT CONSULT

RADIOGRAPHS

- ☐ EMAILED
- ☐ GIVEN TO PATIENT
- ☐ NOT TAKEN

TREATMENT NEEDS

SPECIAL INSTRUCTIONS

3917 University Dr., Suite 150
Durham, NC 27707
(919)439-8999
www.beyonddentaldurham.com