EUN H. HAHN, D.M.D., M.M.Sc.
SARA M. HAHN, D.M.D.

Practice Limited to Prosthodontics

4555 Mattos Drive • Fremont, CA 94536
Tel : (510) 797-3636 • Fax: (510) 797-3660

Date:_____

Introducing:_____
Home Phone: _____
Work Phone: _____

REASON FOR REFERRAL:

- ❑ Consultation
- ❑ Implants
- ❑ Complete Prosthodontic Evaluation & Treatment
- ❑ Evaluation & Treatment of a Specific Area

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

RADIOGRAPHS:

- ❑ Are Enclosed
- ❑ Will Accompany Patient
- ❑ Will Be Sent Upon Request

Taken:_____Teeth #_____

REMARKS:_____

_____

_____

_____

_____

_____

_____

An Appointment Has Been Scheduled On:

_____ DAY _____ DATE _____ TIME

Referred By Dr:_____**Phone:**_____

(White) Patient Copy (Yellow) Doctor's Copy (Pink) Please Send to Dr. Hahn