



**Brian A. Houston, DDS, A.P.C.**  
**Sukhmani Singh, DDS, A.P.C.**  
**PROSTHODONTISTS**

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Dental Group

(T.) 707.745.8002

(F.) 707.745.6347

142 East D Street

Benicia, CA 94510

[www.carquinezdental.com](http://www.carquinezdental.com)

[frontdesk@carquinezdental.com](mailto:frontdesk@carquinezdental.com)

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_

Patient's Telephone: \_\_\_\_\_

Reasons for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Areas of Special Concern:

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

Contact patient to arrange appointment

Patient will call for appointment

Recent Radiographs have been:  mailed to office OR

E-mailed to office

Referring Dr.: \_\_\_\_\_

Address: \_\_\_\_\_

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

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