KATHERINE RODRIGUEZ, DMD

Today's Date: ______________ Appt. Date: ______________ Time: ______________

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Patient's Name

REFERRING DOCTOR INFORMATION

Name: ____

Telephone: ______________________ Email: ______________________

Send Report: ☐ Mail ☐ Email ☐ Phone

Specific Area(s) of Concern:

				A	B	C	D	E	F	G	H	I	J				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	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				

Reason for Referral: ____

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LOCATION

North Miami Beach

15805 Biscayne Blvd, Suite 202

North Miami Beach, FL 33160

P. 305.652.2255

Miami

1330 SW 22nd Street, Suite 406

Miami, FL 33145

P. 305.285.5150

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