



DR. ALEXANDER J. DIMASSA

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Patient Referral Card

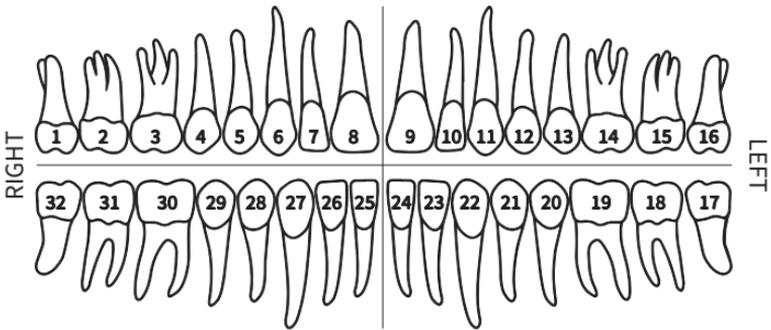
Alexander J. DiMassa, DMD, MSD

Name: _____

Date: _____

Referred By: _____

Please mark the tooth/teeth involved:



- Consultation - Evaluation
- Initial Treatment - Endo Required
- Retreatment
- Leave Post Space

Please provide us with any additional information that may assist us in caring for your patient:
