Patient Referral

A CHILDRENS DENTIST

MICHAEL D. SAXE D.M.D. **JOSHUA L. SAXE D.D.S.**

8710 W. Charleston Blvd. Suite 100 • Las Vegas, NV 89117
(702) 255-0133 • Fax (702) 255-8374

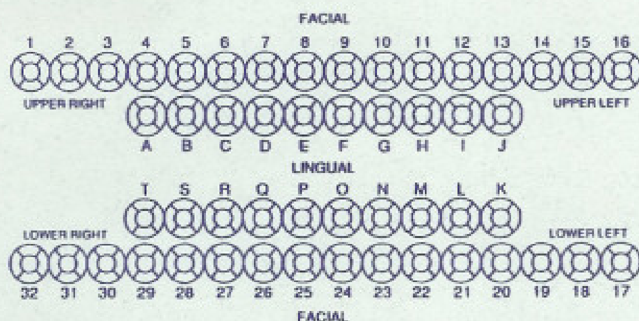
Introducing: ______________________________ Age: ______

Referred by Dr. ______________________________________

Date: ____________________ X-Rays Sent: ____________________

☐ Please complete treatment noted below only.

☐ Please complete treatment noted below and follow-up care.



Remarks:

Patient Instructions:

- Please call our office to schedule your appointment 255-0133.
- Bring this slip and any x-rays you may have with you on your appointment.
- If you have dental insurance please inform us when you call.