

Patient Referral

A CHILDRENS DENTIST

JOSHUA L. SAXE DDS

JACOB OZUNA DMD

8710 W. Charleston Blvd. Suite 100 • Las Vegas, NV 89117
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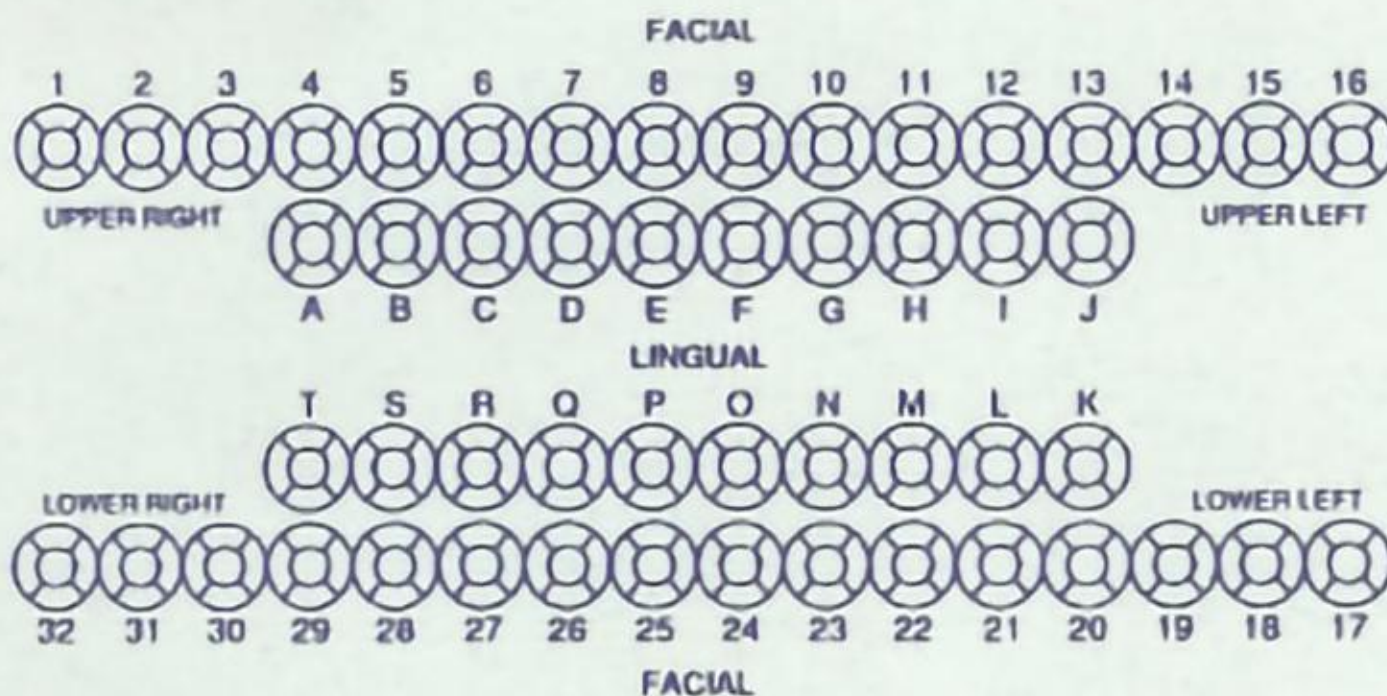
Introducing: _____ Age: _____

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.

