

Patient Referral
**A CHILDRENS
 DENTIST**

JACOB OZUNA DMD

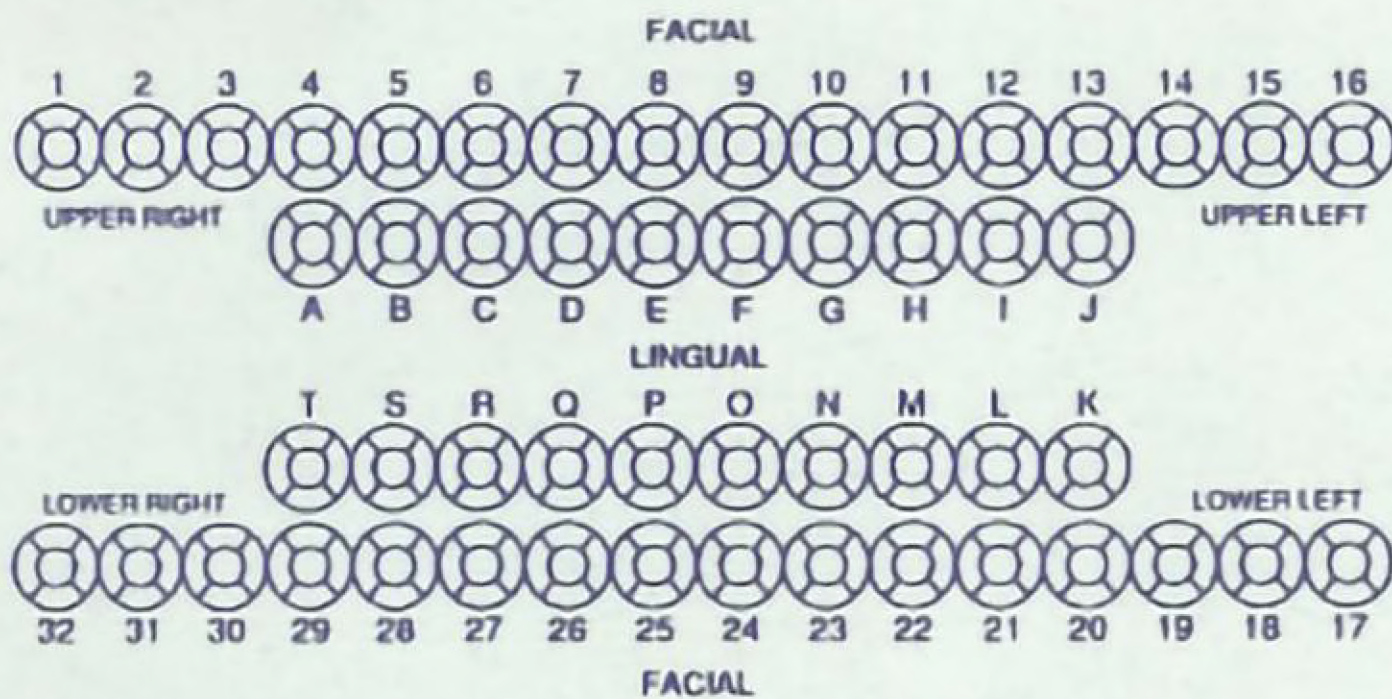
8710 W. Charleston Blvd. Suite 100 • Las Vegas, NV 89117
 (702) 255-0133 • Fax (702) 255-8374

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.

