NORTHERN NEVADA
CHILDREN'S DENTAL AND ORTHODONTICS

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PATIENT NAME ______________________ AGE ______________

LAST EXAM DATE ______________________

LAST PROPHY DATE ______________________

LAST FLUORIDE TREATMENT DATE ______________________

LAST X-RAY DATE ______________________

X-RAY DELIVERY ☐ FAX/EMAIL ☐ PATIENT

WE ARE REFERRING THE PATIENT FOR THE FOLLOWING REASONS

REFERRING PRACTICE ______________________

REFERRING DOCTOR’S NAME ______________________

PHONE NUMBER ______________________

THANK YOU FOR YOUR REFERRAL!