

Provider Referral Form

Shadow Creek Children's Dentistry and Orthodontics

Referring Provider Name: _____

Practice / Facility Name: _____

Phone: _____ Fax: _____

Email: _____

Patient Information

Patient Name: _____

Date of Birth: _____ Parent/Guardian: _____

Phone: _____ Insurance / Medicaid ID: _____

Reason for Referral

☐ Preventative Care ☐ Restorative Care

☐ Orthodontic Evaluation ☐ Emergency / Trauma

☐ Sedation Dentistry ☐ Other: _____

Clinical Notes / Reason for Referral:

Please fax or email this completed form to our office, or have the family call us directly at (725) 204-7082 to schedule an appointment. We will send confirmation of the scheduled visit back to your office.

Shadow Creek Children's Dentistry and Orthodontics

3410 E Centennial Pkwy Suite 110, North Las Vegas, NV 89081

Phone: (725) 204-7082 | Email: shadowcreeknlv@gmail.com