



KIDS DENTAL & ORTHODONTICS

(951)-783-1144

3845 La Sierra Ave, Suite 101B

Riverside, CA 92505

www.wizkidsdental.com

PATIENT REFERRAL FORM

Patient's Name _____

Patient's DOB _____

Patient's Phone# _____

Referring Doctor/Office _____

Referring Office Phone# _____

Instruction/Comments _____

X-Rays

- ☐ Given to patient
- ☐ New x-rays needed
- ☐ Emailed to wizkidsdental@gmail.com

Reason for Referral

- ☐ Pediatric Examination/Treatment
- ☐ Orthodontics
- ☐ IV Sedation
- ☐ General Dentistry

Date _____

All patients will be sent back for their continued care to the referring dentist.

Thank You