

smile sprouts

kids dental

Patient Name: _____ DOB: _____

Phone #: _____

Parent Name: _____

Referring Office Name: _____

Phone #: _____

Date: _____

- | | | |
|---|--|---|
| ☐ First Dental Visit | ☐ Cavities/Early Childhood Caries | ☐ Special Needs Care |
| ☐ Dental Exam/Consultation | ☐ Sedation Dentistry | ☐ Dental Trauma |
| ☐ Other/See notes below: | | |

FOR PROVIDERS

Fax this to (702) 344-1161,
and our team will contact the
family directly to schedule.
Questions?
Call (702) 706-1917

FOR FAMILIES

Ready to schedule?
Call/text (702) 706-1917.
You can also scan this
code or book online at
smilesproutsKD.com



We'll take it from here. 

5693 S Jones Blvd Ste 101, Las Vegas NV 89118