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REQUEST FOR DENTAL RECORDS

In order to protect the continuity of treatment, we would appreciate the transfer of a copy of dental records and any current dental radiographs for the below mentioned patient. Thank you in advance for your prompt cooperation.

RECORD TRANSFER REQUEST FOR:

Patient Name:______________________________________

Street Address:____________________________________

City, State, Zip Code:______________________________

Date of Birth:_____________________________________

Signature:____
(Patient, Parent, or Guardian)

Date:____

Previous Dentist's Name____
Street Address:____
City, State, Zip Code:_______________________________________
Telephone :________________________Fax: __________________________

To be completed by previous dentist

Last Prophylaxis appointment___________________________
Treatment in progress_________________________________
Last Bitewings_______________________________________
Full Mouth Series or Panoramic Film_____________________