TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Request for Transfer of Dental Records

DATE: _____

PATIENT NAME/DATE OF BIRTH: _____

FAMILY MEMBER(S)/DATE(S) OF BIRTH: _____

I HEREBY REQUEST MY DENTAL RECORDS BE SENT TO:

_____

_____

_____

Phone: _____ **Email:** _____

Please share your reason for transferring offices with us:

I am moving to _____

Insurance change _____

Other _____

PATIENT AUTHORIZATION: _____