



Request for Transfer of Records

_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth
_____	_____
Child's Name	Date of Birth

_____	_____	_____
Signature of parent/guardian	Printed Name	Date

Name of NEW Dental Practice: _____

*****If you do not have a new dental practice today please call us back and provide us with an email so we can securely send records.*****

Thank you and we wish you well on your next adventure!