Request for Record Transfer

Date:

Dental Office:

Patient Name:
Date of Birth:

I do hereby give my consent to transfer all my dental records to:

Southington Family Dentistry, PC.
954 South Main Street
Plantsville, CT 06479

Please include all dental radiographs taken within the last three years.

Patient's Signature_____

Witness Signature_____

SFD@SOUTHINGTONFAMILYDENTISTRY.COM Dexis/JPeg