Date _____

Record transfer for _____ DOB _____

_____ FMX

_____ BW's

_____ PA's

_____ Pano

_____ Perio Charting

Last Oral Evaluation _____

Last Prophylaxis _____

Dentist Name _____

Address _____

_____

_____

If you have any questions about treatment on _____ while in our care, please feel free to contact the office.

Release of records:

Patient or Guardian signature _____ Date _____