Allyn G. Perkins, DMD, LLC

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DENTAL RECORDS TRANSFER REQUEST

In order to provide uninterrupted dental service for this patient, we would greatly 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 attention to this matter.

RECORD TRANSFER REQUEST FOR:

Patient's Name _____Birthdate_____/_____/_____

Patient's Address _____

Patient's Social Security Number _____

Please send records to: Allyn G Perkins, DMD
1909 Ritner Highway, Suite 2
Carlisle, PA 17013
Or
Email to: perkins1909@gmail.com

Responsible Party Signature_____Date_____/_____/_____

Previous Dentist's Name: _____

Address: _____

Phone / Fax: _____ / _____

Previous Dentist please complete:

Date of last prophylaxis: _____/_____/_____

Frequency of visits: _____

Outstanding dental treatment: _____

Comments: _____