MARCHWOOD DENTAL

Dr. William Henry, Dr. Bahram Mostaghaci & Associates

Date: _____

Re: Transfer of Records

For Patient Name: _____

I am requesting the transfer of my dental records from the office of

Dr. _____

and/or from the specialist office of

Dr. _____

to Marchwood Dental, Dr. B. Mostaghaci, Dr. W. Henry and Dr. D. Landsman.

I am requesting that duplicates of my radiographs and the date of my last recare exam and hygiene appointment be forwarded to Marchwood Dental. For digital radiographs, I agree to have them sent electronically to this office.

Thank you,

_____
Patient Signature