



Dr. Bahram Mostaghaci and 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. D. Landsman, and Dr. K. Josephson.

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