

PATIENT

Patient Name

Date of Birth

Phone Number

Other Family Members to Transfer:

PREVIOUS DENTIST INFO

Previous Dentist or Practice Name

Address

City

State

Zip

Phone Number

Fax Number

Email Address

RECORDS REQUESTED Requesting 7 years of available records for the patient named from the previous dentist.

Records requested include: (check all that apply) ☐ X-rays ☐ Copy of Perio Chart ☐ Copy of Chart Notes

Other

SIGNATURE

Responsible party -- Type your full name

Date

Print finished document and sign below

TO BE COMPLETED BY PREVIOUS DENTAL OFFICE

Please provide most recent dates of the following services:

Exam:		Prophy:		How often?:	
FMX:		Perio Maintenance:		How often?:	
PANO:		Scaling:			
BWX:		Perio Chart:			

FOR DIGITAL RECORDS, EMAIL TO:
records@uptowndentalpt.com
FOR PHYSICAL RECORDS, MAIL TO:

Uptown Dental Clinic
642 Harrison Street
Port Townsend, WA 98368