REQUEST FOR RECORDS TRANSFER

December 9, 2010

Your practice name: _____
Address: _____
Phone/Fax: _____
Email address: _____

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Patient's Name: «first_nm_txt» «last_nm_txt»

Patient of your practice since: _____ Last appointment: _____

Treatment History: (check all that apply)

_____ Routine Maintenance _____ Periodontal Care

_____ Operative _____ Oral Surgery

_____ Prosthodontics _____ Emergency Treatment

_____ Endodontics _____ Bleaching

Current Recommendations:

Recall Frequency: _____ 4 months _____ 6 months _____ 12 months

Incomplete Treatment: _____

_____

Comments: _____

_____

Enclosures: Panoramic radiograph(s) dated _____

Bitewing radiograph(s) dated _____

Email radiographs to scottfeatherstonedds@yahoo.com or send to fax/address below:

Scott Featherstone DDS Phone 208-726-8272
PO Box 1328 Fax 208-726-5848
Ketchum, ID 83340

I authorize the release of my dental records to Dr. Scott Featherstone

Patient Signature Dated