DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

Transfer of Orthodontic Records/X-rays

Date of Request: _____

☐ **Transfer of Records** ☐ **2nd Opinion**

Reason for Transfer: _____

Patient Name:

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

Contact Phone Number: _____

☐ I do not yet know where you should send the records. I will contact Dental Associates of Walpole with the appropriate forwarding information.

☐ E-mail _____

☐ Mail Records to: _____

_____

_____

Signature (*patient (over 18), parent or legal guardian*): _____

Please Print Name: _____

By my signature above, I am authorizing Dental Associates of Walpole to release any records, including any radiographs that my family (patients listed above) or I may have at this office.