Request to Obtain Patient Records

Patient Name: ____ DOB: ________________
Phone Number: _________________________

Other family members to transfer (list names and DOB's):

____
____
____

Previous Practice/Dentist name: ___________________________________

Address: ____

Phone: _____________________________ Fax: ______________________

E-Mail: ____

Please forward the following patient records that you may have on file:

- X-Rays
- Perio Charting
- Intra-Oral Photos

Please send all records to Office@Southeastsmiles.com

Patient Signature: _____________________________________ Date: _________________

IF YOU HAVE HAD X-RAYS TAKEN BY A PREVIOUS PROVIDER IN THE LAST 5 YEARS, PLEASE FILL OUT THIS FORM AND GIVE TO FRONT DESK. THANK YOU.

Southeast Smiles
3901-D Oleander Dr
Wilmington, NC 28403
Phone: (910)859-7529