Medical Forms Transfer Request
(Please print)

I, ______________________________, am authorizing you and requesting that all of my dental records, including, but not limited to, treatment records, medical information and radiographs be sent to:

Altadena Dental
2100 Devereux Circle Ste. 200
Vestavia, Al 35243

Patient Name:____________________________________

Address: ____________________________________

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D.O.B: ____________________________________

Signature: ____________________________________

Former Dentists Name:_____________________________