STRAIT SMILES
FAMILY DENTISTRY

RECORDS TO BE TRANSFERRED TO STRAIT SMILES

Please complete this section of this form and give it to your previous dental office to release your records to Strait Smiles.

I, (Patient Name) _____

with a birth date of _____, request that my dental records be transferred to:

Mail: **Strait Smiles Family Dentistry, 201 W. Raven St., Belle Plaine, MN 56011, 952-873-6380**
Fax number: **952-873-6382** E-mail: **straitsmiles@straitsmiles.net**

Patient Signature _____ Date_____

If not signed by the patient please indicate relationship:

__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of deceased patient

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Dental Office, please complete the following areas of information.

Dental Office Name: _____ Phone Number: _____

Address: _____

Please send us any available radiographs:
Full series or Panorex (current within 5 yrs), date taken: _____

Bite wings (current within two years), date taken: _____

We would also appreciate the following information about the patient's dental history:

Date of First Visit: _____

Date of Last Visit: _____

Date of Last Prophy & Exam: _____

Work not completed or additional information regarding patient: _____

_____

_____

Thank you for your help! ~ Strait Smiles Family Dentistry

201 West Raven Street • Belle Plaine, MN 56011
OFFICE: 952-873-6380 • FAX: 952-873-6382
www.straitsmiles.com • straitsmiles@straitsmiles.net

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