TRANSFER OF RECORD FORM

_____ Please transfer my dental records to Seacoast Dentistry, PLLC
email: contact@seacoastdentistry.com
fax # 207-282-3793 phone # 207-282-6185

_____ I have requested a copy of my dental records from the office of Seacoast Dentistry to be sent to:

Dentist Name:______________________________

Address:___________________________________

Printed Name: _________________________________

Date: ________________________

Signature:____________________________________

- -

(office use only)

Accepted by: _________________________________

Date records mailed: __________________