DURHAM DENTAL

To: _____ Address: _____
(fill in previous dentist name and address)

Patient Name _____ DOB _____

I request that a copy of my treatment notes and original x-rays be sent to:

Durham Dental
10 Mathes Terrace
Durham, NH 03824
Phone: (603) 868-5129
Fax: (603) 868-5142
Digital x-rays (in jpeg format) send to
durhamdentalnh@gmail.com

If applicable, please forward all information for the following family members:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

_____ _____
Patient Signature Date

Mail/Fax this completed form to your dentist