Pediatric Dentistry

of Central Iowa P.C.

Dr. S.D. Whittemore, D.D.S.

Patient Transfer Request Form

I ________________________request the transfer of records for my child/children or self.

First Name M.I. Last Name D.O.B.

First Name M.I. Last Name D.O.B.

First Name M.I. Last Name D.O.B.

First Name M.I. Last Name D.O.B.

Please Send to: ______________________________________

____

____

____

Reason for Transfer: ______________________________________

____

______________________________________ ______________________

Parent/legal guardian signature(patient signature if over 18yrs old) Date

____

Relationship to patient

Thank you for your time as a patient in our office!

Fax Number: (515) 223-1959 Des Moines (515)964-8811 Ankeny

1000 73rd St, Suite 10 . West Des Moines, Iowa 50265 . (515)223-1298

221 NW School Street . Ankeny, Iowa 50023 . (515)964-3833