COMMUNITY DENTAL CARE of CLAREMONT
One Tremont Street
Claremont, NH 03743
Ph: (603)287-1300 Fax: (603)287-1303

REQUEST for TRANSFER of RECORDS

Date:_____

I, _____, hereby request that you send a copy of the dental records (including x-rays and treatment and payment history) for the following person(s):

_____(DOB) / /)

_____(DOB) / /)

_____(DOB) / /)

Please send to the following office:

_____

_____

_____

_____ _____

Signature of Patient (or Guardian) **Date of Signature**

Reason for transferring:

_____

_____

_____