Pure Dental

Request for the transfer of Dental Records and X-Rays

***Today's Date:**_____ ***Patient's Name:**_____

***Date of Birth:**_____ ***Phone Number:**_____

Please check one of the following three options:

☐ **Transfer to patient**

Name:

Birthdate: _____

Email:_____

☐ **Transfer to office**

Pure Dental
6230 10th St. N. Ste 520
Oakdale, MN 55128

Phone: 651-731-3064
Fax: 651-731-9340
puredentalmn@gmail.com

☐ **Transfer to other office**

Address:

_____

Phone:
Fax:
Email:_____

***Signature (Patient/Guardian):**_____

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

***are required fields to be filled out**