LAKE SARAH DENTAL | 763-575-8038
7500 State Highway 55, Suite 200, Greenfield, MN 55373 frontdesk@lakesarahdental.com

Patient Record Transfer-Release Form

Name of Previous Dental Clinic: ______________________________________
Office Phone: ________________**Office Fax:** ___________________________
Office Email: ______________________________

Today's Date: _________
Patient's Name: ____
Patient's Birth date: ____

Patient Signature: ______________________________ **Date:** _____________

Treatment History to be completed by previous dentist:

Patient of Practice Since: ___________Last Appointment: _______________

___ Routine Exam, Prophy, Fluoride, X-rays:

Last Exam: ___________ Last Prophylaxis: __________
Last Fluoride: _________ Last X-ray: ____________

___General Operative: ____
___Prosthetic: ____
___Endodontics: ____
___Periodontics: ____

Current Recommendations:

Recall Interval: ____
Incomplete Treatment: ____

Comments: ____
____
____
____

Enclosures: _____ Full Mouth Series Date: _____________________________
_____ Bite Wing Date: _____________________________________