PATIENT TRANSFER/RECORDS REQUEST

Date: _____

To: Dr. _____

Fax#: _____

From: _____

Please duplicate any xrays, from the past 3 years, also attach chart/perio notes and mail to the office listed below: If your office uses digital xrays, please send either Dexis format or jpeg to: pdlfamilydentistry@yahoo.com

Ponce de Leon Family Dentistry
Dr. T. Daniel Haeussner, D.M.D.
4 St. Johns Medical Park Dr.
St. Augustine, FL 32086
904-797-9009

Thank you for your assistance.

_____ _____
Patient Signature Date