# PATIENT TRANSFER FORM

RECORD TRANSFER FOR _____

DATE OF BIRTH:_____

TO: _____

_____

_____

Last Seen In Our Office: _____

Last Prophy *or* Perio Maint: _____

Scaling & Root Planing _____

Last Restoration: _____

Sealants Completed: _____

Most Recent Bitewings: _____

Most Recent Pano: _____

Most Recent FMX: _____

Diagnosis Date of Unfinished TX: _____

Patient Comfort/Nitrous: _____

Medical Alerts: _____

_____

Premedication Necessary: _____

Comments: _____

_____

Please feel free to contact our office if you need additional information. Thank You.