STRAIT SMILES
FAMILY DENTISTRY

Please complete the area of the top portion of this form as it applies to you and/or someone you are a guardian for and mail it to your previous dental office to release records.

I, (Patient Name) _____ with a birth date of _____
request that my dental records be transferred to:

Strait Smiles Family Dentistry, 201 W. Raven St., Belle Plaine, MN 56011
Or to straitsmiles@straitsmiles.net

Patient Signature _____ Date_____

I, (Guardian Name) _____ a legal guardian for

(Patient Name) _____ with a birth date of _____
request his/her dental records be transferred to:

Strait Smiles Family Dentistry, 201 W. Raven St., Belle Plaine, MN 56011
Or to straitsmiles@straitsmiles.net

Guardian Signature _____ Date_____

Dental Office, please complete the following areas of information.

Patient's Name_____

Please send us any available radiographs:
Full series or Panorex (current within 5 yrs, date taken): _____

Bite wings (current within two years, date taken): _____

We would also appreciate the following information about the patient's dental history:

Date of First Visit: _____

Date of Last Visit: _____

Date of Last Prophy & Exam: _____

Work not completed: _____

Please call 952-873-6380 with any questions or concerns you may have.

Thank you for your help, Strait Smiles Family Dentistry