ORANGE CITY DENTISTRY
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TRANSFER OF CARE

Date: _____

To: _____

_____

_____

Record Transfer for:

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

History:

LATEST FULL MOUTH: _____

LATEST PANOREX: _____

LAST BITEWINGS: _____

Comments:

_____

_____

PATIENT SIGNATURE: _____

Parent or guardian signature required for patients under the age of 18.