

**REQUEST FOR RECORDS TRANSFER**

December 9, 2010

Your practice name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

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Patient's Name: «first\_nm\_txt» «last\_nm\_txt»

Patient of your practice since: \_\_\_\_\_ Last appointment: \_\_\_\_\_

Treatment History: (check all that apply)

\_\_\_\_\_ Routine Maintenance

\_\_\_\_\_ Periodontal Care

\_\_\_\_\_ Operative

\_\_\_\_\_ Oral Surgery

\_\_\_\_\_ Prosthodontics

\_\_\_\_\_ Emergency Treatment

\_\_\_\_\_ Endodontics

\_\_\_\_\_ Bleaching

Current Recommendations:

Recall Frequency: \_\_\_\_\_ 4 months      \_\_\_\_\_ 6 months      \_\_\_\_\_ 12 months

Incomplete Treatment: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Enclosures:    Panoramic radiograph(s) dated \_\_\_\_\_

                  Bitewing radiograph(s) dated \_\_\_\_\_

Email radiographs to [scottfeatherstonedds@yahoo.com](mailto:scottfeatherstonedds@yahoo.com) or send to fax/address below:

Scott Featherstone DDS  
PO Box 1328  
Ketchum, ID 83340

Phone 208-726-8272  
Fax 208-726-5848

I authorize the release of my dental records to Dr. Scott Featherstone

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Dated