Aesthetic Dentistry of Charlottesville, P.C.
900 Gardens Boulevard, Suite 600
Charlottesville, Virginia 22901
434/984-3455 434/973-4874 fax
www.cvillesmiles.com

Transfer To

I, _____
Patient, Parent, Guardian (Current Patient of Aesthetic Dentistry of Charlottesville)
am changing dentists and authorize the release of my records to my new dentist office. Please forward my records (from ADC) to the following office:

Dr. - _____

Address - _____

City - _____State - _____Zip - _____

Telephone Number - _____

E-mail Address (if x-rays are able to be sent electronically) - _____

Family member/s names - _____

_____

Signed - _____Date - _____

****

Transfer From

I, _____
Patient, Parent, Guardian
am changing dentists and authorize the release of my records to the office of:

Aesthetic Dentistry of Charlottesville
900 Gardens Boulevard, Suite 600
Charlottesville, Virginia 22901
manager@cvillesmiles.com (please e-mail x-rays, if possible)

Family member/s names - _____

_____

Signed - _____Date - _____