REQUEST FOR INFORMATION FROM PREVIOUS DENTIST

DR: _____

_____

_____

DR. PHONE: _____ **FAX: _____**

DR. EMAIL: _____ _

PATIENT NAME(S): _____

_____

Please use this letter as authorized to forward a copy of **X-RAYS, TREATMENT/CHART NOTES, AND PROBINGS** for the patient(s) listed above to the following:

EMAIL info@jasperdentistry.com
MAIL: Jasper Dentistry
2752 Pleasant Road
Suite 106
Fort Mill, SC 29708

Your prompt attention to this matter is greatly appreciated. If you have any questions regarding this form, please contact us 803.548.4353.

_____SIGNATURE **_____ DATE**