



Drs. Ellis, Green and Jenkins

Pediatric Dentistry, Orthodontics & General Dentistry

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Records Request Form

Patient's Name(s): _____

Patient's DOB: _____

Please send x-rays and records to:

Contact #: (H) _____

(C) _____

Reason for Transfer: _____

Thank You,

Signature

Date

****PLEASE INCLUDE A COPY OF YOUR LICENSE OR OTHER FORM OF PHOTO ID IN ORDER TO RECEIVE YOUR RECORDS****

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