Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_

**Transfer Records To:**

**Crestridge Dental**

50 McAndrews Rd. E.

Burnsville, MN 55337

Phone: 952-892-5050

Fax: 952-892-5542

Digital Xrays: Crestridgedental50@gmail.com

Please send current xrays and date of last prophy.

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_