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: info@crestridgedental.com

Please send current xrays and date of last prophy.

Patient or Guardian Signature: _____ Date: _____