Woodlane
Family & Cosmetic Dentistry, P.A.

Consent to transfer records to Woodlane Family & Cosmetic Dentistry, PA

I, _____, understand that by signing this form, I am giving my consent to have my records transferred to Woodlane Family & Cosmetic Dentistry.

Please list all family members of records to transfer and date of birth:

Name of previous clinic:_____

Location of previous clinic:_____

Phone number of previous clinic:_____

Signature_____ Date_____