ROANOKE
PEDIATRIC DENTISTRY

Request for Transfer of Records

I hereby request and give my permission to provide Dr. Sheppard at Roanoke Pediatric Dentistry any and all information regarding past dental care for:

Patient Name(s):	Date of Birth(s)
_____	_____
_____	_____
_____	_____
_____	_____

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records. Please have these records sent to:

Dr. Corey J. Sheppard

Roanoke Pediatric Dentistry

6112 Peters Creek Road

Roanoke, VA 24019

Email: info@secure.roanokepediatricdentistry.com

Fax: (540) 563-1300

Parent/ Guardian Signature: Date:

_____ _____