

From the office of:  
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**Patient Request**  
**for**  
**Transfer of Dental Records**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Transfer records for the following patients:

| <u>Name</u> | <u>Date of Birth</u> |
|-------------|----------------------|
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |
| _____       | _____                |

Transfer To: \_\_\_\_\_ Transfer From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for leaving: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature x \_\_\_\_\_ Date \_\_\_\_\_

PLEASE E-MAIL X-RAYS TO:  
randi@mymichigandentist.com