Aesthetic Dentistry of Charlottesville, P.C.
900 Gardens Boulevard, Suite 600
Charlottesville, Virginia 22901
434/984-3455 434/973-4874 fax
www.cvillesmiles.com

Transfer To

I, ____
Patient, Parent, Guardian (Current Patient of Aesthetic Dentistry of Charlottesville)
am changing dentists and authorize the release of my records to my new dentist office. Please forward my records (from ADC) to the following office:

Dr. - ____

Address - ____

City - ______________________ State - ______________ Zip - ______________

Telephone Number - ____

E-mail Address (if x-rays are able to be sent electronically) - ______________________________

Family member/s names - ____

____

Signed - ______________________________ Date - ______________________________

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Transfer From

I, ____
Patient, Parent, Guardian
am changing dentists and authorize the release of my records to the office of:

Aesthetic Dentistry of Charlottesville
900 Gardens Boulevard, Suite 600
Charlottesville, Virginia 22901
admin2@cvillesmiles.com (please e-mail x-rays, if possible)

Family member/s names - ____

____

Signed - ______________________________ Date - ______________________________