PLEASE USE THIS FORM TO RELEASE THE RECORDS FROM YOUR PREVIOUS DENTIST IF YOU HAVE NOT ALREADY DONE SO.
MAIL DIRECTLY TO YOUR PREVIOUS DENTIST
-THANK YOU

Patient Transfer Form

I, ______________________, am requesting that my records be sent to:

Gary Sickles, DDS
171 S Maize Rd
Wichita, KS 67209
Ph: 316.721.2010

I would also like the records of my minor children sent:

1.___________________________

2.___________________________

3. ___________________________

4.___________________________

PLEASE INCLUDE ANY OF THE FOLLOWING INFORMATION IF AVAILABLE:

Date of last examination:
Date of last Fluoride treatment:
Date of last Radiographs if known & copies if available:
Bitewings:
Full Mouth:
Panoramic:
Remarks:

Patient Signature