



[320 Midland Parkway, Suite A | Summerville, SC 29485](#) | [843-203-5043](tel:843-203-5043) | delitedental.net

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Other Family Members to Transfer: _____

Previous Dentist Name/Practice: _____

Address: _____ Phone Number: _____

Fax: _____ Email: _____

I hereby authorize for my records to be transferred to Delite Dental. Please include the following

- Medical/Dental/Financial History
- Treatment and Progress Report
- Dental X-Rays
- Professional Assessment

If records are digital please email to: Office@delitedental.net

or fax to: [843 282 7699](tel:843-282-7699)

Mail to :

| |
|---|
| Delite Dental 320 Midland Parkway, Suite A Summerville SC, 29485 |
|---|

Patient Signature: _____ Date: _____