320 Midland Parkway, Suite A | Summerville, SC 29485 | 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

Mail to :

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

Patient Signature: _________________________________ Date: ____________________