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Dear Dr. \_\_\_\_\_,

I am now a patient of Dr. Richard M. Yarbrow. I would like to have my dental treatment record transferred. Please include clinical records for complex treatment, proposed treatment that was not completed, or originals of any current radiographs (*current* includes bitewings within the past year or full mouth survey within the past five years only).

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Patient Name (please print)

Date of Birth

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Patient Signature

Date