Lewis Dental Group

J.Brooke Lewis, DMD
Christen Sauers, DDS
Brad Pieszala, DMD
Brigham Lewis, DMD

Record Transfer

My permission is granted for _____to transfer a copy of my entire dental records including written treatment and acceptable copies of the most recent radiographs (full mouth series and bitewings).

Please send them to the office of:

Lewis Dental Group
103 East Main St.
PO Box 490
Silverdale, PA 18962

lewisdentalgroup@outlook.com

Your cooperation in this matter is appreciated.

Patient Name:_____

Patient or Guardian Signature:_____

(Print Name of Guardian Signed for Minor):_____

Patient Address:_____

_____

_____

Witness:_____

Date:_____