CORNERSTONE
FAMILY DENTAL

Patient Transfer Request

Date: _______________
Patient Name(s): ____

Please transfer my/our records/xrays
From:________________________________
Name of practice or doctor

____
Address, city, state, zip

____
Phone number

To: Cornerstone Dental Group
1604 Missouri Ave.
Carthage, MO 64801
417-358-3361

To other office: Please email digital images to ceriotero@cornerstonefamilydental.com and include the date images were acquired. **Please advise if this patient takes a preventive antibiotic before dental procedures. If so, please inform us of the condition that requires it and the antibiotic name and dosage information as well as the medical doctor's name who cares for this patient**.

Signature: ___________________________________ Date: ____________

Mark F. Saladin, DMD
Louis M. Drackert, DDS
Jack G. Robbins, DDS

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