Date: _____

Dentist: _____

_____

_____

Please transfer the following patient(s) complete dental records, including all current x-rays to / from:

Dental Distinction/Dr. Jason Petkevis
126 Pottstown Pike
Chester Springs, PA 19425

For electronic/digital records please email to: crissy@chesterspringsdentist.com

Patient Name: _____

_____

_____

Patient Authorization: _____

_____

_____

All patients over the age of 18 years must sign for their own records.