Cochran, Soares, and Associates

Pediatric Dentistry

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**All are Diplomats of the American Board of Pediatric Dentistry*

Date Received: _____

Patient Name: _____

Patient Date of Birth: _____

☐ X-rays only ☐ Full written records/history

Reason for records: _____

If transferring to a new office, please list the appointment date: _____

Please choose an option to have records sent:

Email records and/or x-rays to: ☐ Personal ☐ Dental Office

If sending to personal email: ☐ Encrypted ☐ Unencrypted

Email Address: _____

Parent/Guardian Signature (or if patient is 18+ years old they must sign)

Signature: _____ Date: _____

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