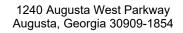


Tina P. Moses, DMD, PC

Pediatric Dentistry





RECORDS TRANSFER REQUEST

DATE		
I authorize the transfer of dental and medical such, and request that they are transferred to		elevant to dental treatment, or copies of
Tina P. Moses, DMD, PC 1240 Augusta West Parkway Augusta, GA 30909-1854 706-863-6262 (o) 706-863-6465 (f)		
Email records to: office@mosespediatricden	tistry.net	
PRINT NAME OF PATIENT		DATE OF BIRTH
PRINT NAME OF PATIENT	•	DATE OF BIRTH
PRINT NAME OF PATIENT		DATE OF BIRTH
PRINT NAME OF PARENT/GUARDIAN		PARENT/GUARDIAN SIGNATURE

Office: 706-863-6262 **Fax:** 706-863-6465 **Email:** drtinamoses@comcast.net