Pediatric Dentistry

*Barry P. Setzer, D.D.S. - *Stephen D. Cochran, D.M.D. - *Flavio M. Soares, D.D.S. - *Karen A. Hubbard, D.D.S.
*All are Diplomates of the American Board of Pediatric Dentistry

Date Received: _____

Name and date of birth of Child/Children:

_____

X-rays only or 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

Or Mail them to:

_____

_____

Parent/Guardian (or if patient 18 years or older they must sign)

_____

Signature Date

BAYMEADOWS OFFICE
8355 Bayberry Road, Jacksonville, FL 32256
P 904-733-7254
office@setzerandcochran.com

PONTE VEDRA BEACH OFFICE
340 Front Street, Suite 770, Ponte Vedra Beach, FL 32082
P 904-473-0600
pvboffice@setzerandcochran.com

WWW.SETZERANDCOCHRAN.COM