Request to Transfer Records to Center for Pediatric Dentistry

I request that all dental records for my children listed below be transferred to Center for Pediatric Dentistry, Dr. Lee Baker.

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Please send records to:

Center for Pediatric Dentistry
1243 Augusta West Parkway
Augusta, GA 30909
706-855-8989 Telephone
706-855-0321- Fax
Email records to: appointments@drleebaker.com

Electronic medical records are preferred. If possible, please e-mail records to the e-mail listed above.

Thank You!

Signature: _____ Dated: _____
Relationship to patient: _____