



Deborah Beaty, DDS

Medical Forms Transfer Request

(Please print)

I, _____, am authorizing you and requesting that all of my dental records, including, but not limited to, treatment records, medical information and radiographs be sent to:

Deborah L. Beaty D. D. S., P.C.
111 N. Wabash, Suite 1921
Chicago, IL 60602

Patient Name: _____

Address: _____

Signature: _____