MINOCQUA FAMILY DENTAL

Dental Records Release Form

Patient Name To Transfer:_____

Date of Birth:_____ Phone Number:_____

Other Family Members To Transfer:_____

Previous Dentist or Practice Name:_____

Address:_____

City/St/Zip:_____

Phone Number:_____

Email Address:_____

Please forward any of the following information that you have: x-rays, perio charting, and photographs to Minocqua Family Dental.

I hereby give you permission to release any and all of my dental records to: Minocqua Family Dental

I hereby give Minocqua Family Dental permission to release any and off of my dental records

to:_____

_____ _____

Patient Signature (parent if minor) Date