Page Family Dentistry
– SOMETHING TO SMILE ABOUT –

RELEASE OF RECORDS AUTHORIZATION

I want the records from my previous dentist to be released to Page Family Dentistry:

What is your previous dentist's name/practice name?

What is your previous dentist's address?

What is your previous dentist's phone number?

What is your previous dentist's email address?

Please send a copy of:

- ☐ All of my dental records (x-rays, chart notes, periodontal charting)
- ☐ Dental xrays only (bitewings, Panorex, Full Mouth Series taken within the past 5 years)

-or-

I want to release my records from Page Family Dentistry to my new dentist:

What is your new dentist's name/practice name?

What is your new dentist's address?

What is your new dentist's phone number?

What is your new dentist's email address?

Please send a copy of:

- ☐ All of my dental records (x-rays, chart notes, periodontal charting)
- ☐ Dental xrays only (bitewings, Panorex, Full Mouth Series taken within the past 5 years)

RELEASE OF RECORDS AUTHORIZATION

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email.

Practice Name: Page Family Dentistry Practice Address: 107 E Locust St, River Falls, WI 54022
Practice Phone number: (715) 425-5780

Patient Name (print): _____ DOB:_____

Patient's signature: _____Date: _____