PEARL DENTAL

DENTAL RECORDS

RELEASE FORM

PATIENT NAME:

DATE OF BIRTH: **PHONE:**

OTHER FAMILY MEMBERS TO TRANSFER:

PREVIOUS DENTIST OR PRACTICE:

NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

PHONE NUMBER: **FAX NUMBER:**

I hereby request and authorize you to provide the most current x-ray for myself and/or family members listed above. (BWX within 1 year, FMX/Pano within 5 years and any other miscellaneous x-rays.)

I expressly release from liability the above named person or entity from any and all liability from compliance with this request and disclosure of the requested information.

PARENT/GUARDIAN SIGNATURE:

PRINTED NAME:

DATE:

1716 2nd Avenue North
Sauk Rapids, MN 56379

PHONE
320-654-9999

FAX
320-240-2319

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