Wildflower Dental

DENTAL RECORDS RELEASE FORM

Date:_____

Patient Name:_____

Date of Birth:_____Patient Phone#:_____

Previous Dentist or Practice Name:_____

Address:_____

City/State/Zip:_____

Email:_____

Phone:_____

Authorization to Release Records:

Please forward any of following information that you have on file to Wildflower Dental:
x-rays, probing depth chart, charting, photographs and existing implant info
Additional information requested:_____

I hereby give the above named dental practice and/or doctor permission to release any and all of my dental records to Wildflower Dental.

_____

Patient Signature *(Parent signature if patient is a minor)* Date

Email digital records to:	Mail to:
email.us@wildflowerdentalaz.com	Wildflower Dental 18818 N. 99th Avenue Sun City, AZ 85373