Dental Records Release Form

Patient Name: ____

Date of Birth: ______________________

Phone # ____________________________

Other Family Members to Transfer: ______________________________________

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Previous Dentist or Practice Name: ______________________________________

Address: ____

City, State, Zip: ____

Phone # ____________________________

Please forward any of the following information that you have: x-rays, probing charts, charts, and photographs to Arbor Dental Group.

I hereby give you permission to release all of my dental records to Arbor Dental Group.

____ ________________________

Patient Signature (parent if minor) Date

If records are digital, please e-mail to: Info@thesmilearchitects.com

Or mail to:
Arbor Dental Group
3151 S. White Road, Suite 104
San Jose, CA 95148
408-270-2273