AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

Date:

I hereby authorize

Address:

To furnish all current radiographs and dental treatment information related to my care to :

Valley Dental Group
7501 Golden Valley Rd
Golden Valley, MN 55427

763-544-2213

I also authorize release of such records for my dependants listed below:

Name: Birthdate:

Name: Birthdate:

Name: Birthdate:

Name: Birthdate:

Signature: Birthdate:

Print Name:

06/09 bap

PATIENT RECORD TRANSFER:

Patient's Name DOB:

Patient of Practice Since: Last Appt:

Treatment History:

Preventative Care (Recall interval , Due)

Sealants

Operative Treatment

Prosthetic

Endodontics

Periodontics

Oral Surgery

Orthodontics

Emergency/infrequent treatment only

Other

The following treatment has been recommended but is incomplete:

Comments:

Bitewings/dated Last taken

Panorex/dated

FMX/dated

Please enclose x-rays if BW’s taken within 2 years, Pan & FMX taken within 5 years