Dental Records Release Form

Patient Name to Transfer : _____ Date of Birth : _____

Other Family Members To Transfer : _____

Previous Dentist Name or Practice : _____

Address: _____
Street City State Zip Code

Phone Number : _____

Please forward any of the following information that you have: Radiographs, Probing Depth Chart, Charting, and Photographs to The Dentist On Boones Ferry

I hereby give you permission to release any and all of my dental records to The Dentist On Boones Ferry

_____ _____
Patient Signature Date

If records are digital, please email to Office@TheDentistOnBoonesFerry.com

Or Mail To:

The Dentist On Boones Ferry
3900 Douglas Way
Lake Oswego, OR 97035