FAMILY DENTAL WELLNESS
Complete Health Dentistry

Dental Records Release Form

Patient Name: _____ Date of Birth: _____

Previous Dentist or Practice Name: _____

Address: _____
City/St/Zip : _____

Phone number: _____ Fax number: _____

Please forward any of the following patient information that you have included, but not limited to: x-rays, probing depth chart, charting, and photographs to Family Dental Wellness.

I hereby give you permission to release any and all of my dental records to:

FAMILY DENTAL WELLNESS
2108 WEST STATE STREET
OLEAN, NY 14760

If records are digital please send to
amym@myfamilydentalwellness.com

May also be faxed to (716) 379-8488.

We appreciate your prompt attention to this request. Thank You!

_____ _____
Patient Signature Date

☐ Check here if you are requesting additional family member's under 18 records and list names below

_____
_____
_____
_____