

Record Release

Information below provided for your office

Request the following information from your office

Patient: First Name

-

Patient: Last Name

-

Last Appointments, please provide dates

Prophy:

-

Fluoride:

-

Full Series X-rays:

-

Bitewings:

-

Panoramic:

-

Records Release (To be completed by patient):

Name and address of former dentist:

-

I authorize the release of my (and/or family's) dental records to/from Dr. Christopher Pawelek, DDS.

Patient Name:

-

Signature: (ESign)

Date :