DUNGENESS DENTAL

B. Travis Johnson, D.D.S.

REQUEST TO RELEASE DENTAL RECORDS

I hereby authorize and request ____ to disclose and give copies of any and all records and information concerning the undersigned to Dungeness Dental, including but not limited to dental records (including operative records), diagnosis, dental history, findings and procedures, radiographs, and any other pertinent information pertinent to my dental work.

In consideration of such disclosure on the part of the above named person or institution, I hereby release them from any and all liability arising from such disclosure.

Patient Name ____ Date of Birth______________________

Patient/Guardian Signature ____ Date ____________________________

Office of Previous Dentist____

Address____

Phone ____ Fax ____

Email____

TO BE COMPLETED BY PREVIOUS DENTIST

Date of last visit to your office ____

Date of last prophy__________________________________ Or PMT ____

Date of last complete full mouth X-rays/Pano ____

Perio Charting____

Please provide copies of perio charting, and proposed treatment, and most current x-rays. Please email x-rays to info@dungenessdental.com.

DUNGENESS DENTAL
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360.681.3966 – fax