daxon
DENTISTRY

REQUEST FOR RELEASE OF RECORDS

PATIENT NAME _____

PATIENTS DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREVIOUS DENTAL OFFICE: _____

OFFICE PHONE #: _____

PATIENT SIGNATURE _____ DATE _____

I HEREBY REQUEST THAT MY DENTAL RECORDS BE RELEASED TO:

Daxon Dentistry
Address: 111 2nd Ave NE # 1104 -- St Petersburg, FL 33701
e-mail: info@daxondentistry.com
Phone: (727) 282-1970 -- Fax (727) 608-1980

Please include any x-rays (in jpeg format please) and periodontal charting