Pillager Dental

Dental Records Release Form

Patient name: _____

Date of Birth: _____ Phone number_____

Other family members:

_____

_____

Previous Dentist or Practice Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, perio and restorative charting and photographs.

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

_____ _____

Patient Signature (parent if minor) Date

Pillager Dental

Dr. Heidi Fletcher, DDS

727 Buckskin Ave W

Pillager, MN 56473

218-746-4555, fax 218-746-4558

office@pillagerdental.com