DR. YULIA PATERSON
DDS, NMD, IBDM

DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: _____

Date of Birth: _____ Phone Number: _____

Other Family Members to Transfer:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Previous Dentist or Practice Name: _____

Office Address: _____

City / State / Zip Code: _____

Office Phone #: _____

Office Email Address: _____

Please forward any of the following that you have on file for the patient(s):

- ☐ Bitewing x-rays and Periapical x-rays taken within last **24 months**
- ☐ Panorex or Full Mouth Series taken within the last **5 years**
- ☐ CBCT taken within the last **5 years**
  (We can coordinate how to get CBCT to our office when applicable)

_____

Patient Signature (Parent/Guardian if a minor) Date

Email records to: info@linkdentalhealth.com