

# Simply Smiles Dental Portland

## DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Other family members to transfer: \_\_\_\_\_

Previous Dentist or Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/St/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Simply Smiles Dental Portland.

I hereby give you permission to release any and all of my dental records to Simply Smiles Dental Portland.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If records are digital, please email to:

[info@simplysmilesportland.com](mailto:info@simplysmilesportland.com)

Or mail to:

Simply Smiles Dental  
1616 SW Sunset Blvd., Suite A  
Portland, OR 97239  
503-244-4837 (Office)  
503-293-3480 (Fax)