Beadnell Family Dentistry

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: xrays, probing depth chart, charting, and photographs to Beadnell Family Dentistry.

I hereby give you permission to release any and all of my dental records to Dr. Melissa Beadnell DMD PC.

_____ _____

Patient Signature Date

If records are digital, please email to:

info@beadnellfamilydentistry.com

Or mail to:

Beadnell Family Dentistry
1616 SW Sunset Blvd., Suite A
Portland, OR 97239
503-244-4837 (Office)
503-293-3480 (Fax)