DENTAL RECORDS RELEASE FORM

Patient Name to transfer:_____

Date of Birth: _____

Previous Dentist or Practice Name: _____

Address:_____

City/St/Zip:_____

Phone Number:_____

Please forward the following information: x-rays, probing depth chart, charting (for prior dates of service) and photographs to WAHOO DENTAL ASSOCIATES PC.

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

WAHOO DENTAL ASSOCIATES.

Patient or Guardian Name: _____
(Please Print)

X_____Date: _____
Patient or Guardian Signature

Please mail records to: WAHOO DENTAL ASSOCIATES
357 EAST 4TH STREET
WAHOO, NE 68066
(402) 443-5959

Email: wahoodental@securepracticemail.com

*Please return form to our office at least 2 weeks prior to your first appointment.