york dental

3205 West 76th St.
Edina, MN 55435

Phone 952-841-0122
Fax 952-896-0010

Request for Release of Dental Records to York Dental

Patient Information (to be completed by patient)

Patient Name: _____
First Middle Initial Last

Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Date of Birth: _____ Soc. Sec. No.: _____

Previous Dental Office: _____
(Clinic Name)

To be completed by previous dental office

☐ Last Full Series Films and/or Pano Date: _____
Please forward if within five years

☐ Last Bitewing Series Date: _____
Please forward if within one year

☐ None current

Contact Name/Phone: _____

Please indicate any current recommendations or concerns: _____

_____

_____

Forwarding Address

Please forward requested information to York Dental via:

Email: info@yorkdental.com

Mail: 3205 W. 76TH Street, Suite 1
Edina, MN 55435

I hereby authorize the release of all indicated information to: YORK DENTAL, P.L.L.C.

_____

Signature of patient, parent, or legal guardian (Required) **Date**