IDEAL FAMILY
DENTAL

700 W. Ironwood Drive Suite 241
Coeur d'Alene, Idaho 83814
(208) 664-4831

Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____

Phone Number: _____

Other Family Members to Transfer: _____

_____

Previous Dentist or Practice Name: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Ideal Family Dentistry.

I hereby give you permission to release any and all of my dental records to Ideal Family Dentistry.

Patient Signature (parent if a minor): _____

Date: _____

If records are digital, please e-mail to:

Info@idealfamilydentistry.com