Dentistry In Oak Ridges

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Patient releases of records. I, _____authorize the release of my dental radiographs/dental records to Dr._____ at Dentistry in Oak Ridges.

What is the name of current dentist? Dr_____.

Contact number of current dentist_____.

To be completed by dental office. Please provide the following information:

Date of last full mouth x-rays:_____

Date of last complete exam: _____

Date of last recall exam: _____

Date of last appointment in your office: _____

Patient Signature: Date:

_____ _____