APOLLONIA DENTAL

RELEASE OF RECORDS

I_______________________________ (NAME OF PATIENT/OR GUARDIAN IF MINOR) HEREBY AUTHORIZE MY RECORDS TO BE RELEASED TO APOLLONIA DENTAL. PLEASE INCLUDE ALL X-RAYS TAKEN IN THE PAST FIVE YEARS FROM THE DATE LISTED BELOW.

PATIENT INFORMATION

NAME ______________________________________NICKNAME________________BIRTHDATE _______________

ADDRESS _____________________________CITY ____________________ STATE_____________ZIP_________

PREVIOUS DENTIST INFORMATION

DENTIST'S NAME___________________________________PHONE #_________________FAX #_______________

ADDRESS______________________________CITY ____________________STATE _____________ZIP_________

X____

SIGNATURE DATE

____

PRINT NAME RELATIONSHIP TO PATIENT

SEND RECORDS & XRAYS TO

APOLLONIA DENTAL
200 MAIN STREET EXT.
MIDDLETOWN, CT 06457
(F) 860.343.0596
(E) apolloniadental@comcast.net

PLEASE INCLUDE DATES OF

LAST CMX/FMS______________________________
LAST PANO_________________________________
LAST BWX__________________________________
LAST RECALL_______________________________
LAST EXAM_________________________________