Authorization to Release Records

Previous DDS: _____

Previous DDS Phone: _____

Regarding patient (Name/DOB): _____

For Dental Office Only:
Please answer from patient records

Date of first visit to your office: _____

Date of last set BW's: _____

Date of last PANO/FMX: _____

Date of last PRO/Perio/SCRP: _____

Fillings last two years: _____

_____

Crowns/Bridges last 10 years: _____

_____

Please send completed form and X-rays to:

Bob Koenitzer DDS Inc/Austin Hartford DMD
101 Lynch Creek Way, Ste A
Petaluma, CA 94954
Email: Records@PetalumaSmiles.com
Ph) 707-766-6666
Fax) 707-763-1614

Signed by Patient, or guardian: _____

Printed Name/relationship: _____

Date: _____

Dir: Z:\sharedcloud\hydra\data\tmp\pool-6-thread-1-13838644434523512343.octo\c9510d15-aba0-45ba-814b-a970c4bbddbb.docx