Please send records to : info@badlandsdental.com

Previous Dentist/Office **Patient's Name**

Date of Birth **Phone Number**

Please provide a copy of the dental record as indicated below:

_____Bitewing Xrays (If less than 1 year old)
_____Full Mouth or Pano Xrays (If less than 5 years old)
_____Periodontal Charting
_____Date of last Root Plane/Scale (if applicable)
_____Other:____

*Please forward my requested dental information to the Dentist listed above. I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release of the above requested information only.

____
Signature of patient or patient's authorized representative

____
Relationship or status if signed by anyone other than patient (Parent, legal guardian, etc.)

Date: ______________________________

389 15th Street West
Dickinson, ND 58601

701-483-1385

info@badlandsdental.com