



## FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370

Phone: (360) 779-1566 | Fax: (360) 779-6879

### RECORDS REQUEST FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

To: \_\_\_\_\_

**Dentist/Denturist/Doctor/Hospital/Healthcare Facility**

\_\_\_\_\_  
**City, State**

I hereby authorize the release of my dental records including (the dates will be filled out by your previous dental office once they receive this form):

1. Bitewing x-rays within the last 2 years with the date they were taken: \_\_\_\_\_
2. FM series and/or panoramic x-ray within the last 5 years with the date they were taken:  
\_\_\_\_\_
3. Date of most recent exam: \_\_\_\_\_
4. Date of most recent cleaning: \_\_\_\_\_
5. Has the pt ever had any history of periodontal therapy (SRP)? Yes or No
6. If so, what are the dates of UR: \_\_\_\_\_ LR: \_\_\_\_\_ UL: \_\_\_\_\_  
LL: \_\_\_\_\_

to be sent to:

**Wonder Family Dental & Dentures**  
**19410 8th Ave NE Suite 102**  
**Poulsbo, Washington 98370**  
**Phone: (360) 779-1566**  
**Fax: (360) 779-6879**  
**Email: [contact@wonderdentaldentures.com](mailto:contact@wonderdentaldentures.com)**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date