WONDER
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

_____ _____
Signature of Patient **Date**