Wolfe Family Dental

2115 NE 42nd Ave, Portland OR 97213 (503) 281-8110 Frontoffice@wolfefamilydental.com

Date: _____ _____ Send _____ Request

Patient Information:

Name _____

Date of Birth _____

Phone _____

Reason for request:

_____ Transferring Care

_____ Legal Purposes

_____ Insurance purpose

_____ Personal use/other

PLEASE PROVIDE A COPY OF THE DENTAL RECORD AS INDICATED BELOW

_____ Bitewing X-rays (if less than 1yr)

_____ Full mouth or pano (if less than 5 yrs)

_____ Most recent perio chart

_____ Other: _____

Name of Dentist/Other: _____

Address _____

Phone _____

Email _____

Fax _____

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.

_____

Signature of patient or authorized representative

_____

Relationship or status if signed by anyone other than patient