Bates Dental, PS
2700 S Southeast Blvd, Suite 104
Spokane, WA 99223
Phone (509) 795-5878   Fax (509)383-4199

Dental Records Release Form

Patient Name to Transfer: ____

Date of Birth: ______________________

Phone Number: ________________________

Other Family Members to Transfer:

____

Previous Dentist or Practice Name: ____________________________________

Address: ____

City, State, Zip: ____

Phone Number: _________________________________

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Bates Dental, PS.

I hereby give you permission to release any and all of my dental records to Bates Dental, PS

______________________________________ ____________________
Patient Signature (parent if a minor) Date

If records are digital, please e-mail to:

Info@batesdental.com

Or mail to:

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Spokane, WA 99223