DENTAL RECORDS RELEASE FORM

Patient Name:_____ Date of Birth:_____

I hereby authorize the doctor and staff of ***Paga Family Dentistry, PLC*** *to release and/or request records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examination(s), treatment(s), x-ray(s) and other records that pertain to my dental health.*

Dental Practice/Dentist Name:_____

Address:_____

City, State, Zip:_____

Phone Number:_____ Fax:_____

Email:_____

Please forward any of the following information that you have: Probing Depth Chart and X-Rays to:

Paga Family Dentistry, PLC
112 S. Lake Street
Boyne City, MI 49712
Fax: 231.437.5141
pagadental@gmail.com

X_____ _____

Patient/Guardian Signature Date