AUTHORIZATION AND REQUEST FOR PREVIOUS DENTAL RECORDS/RADIOGRAPHS

PATIENT NAME_____ DATE OF BIRTH _____

PARENT OR GUARDIAN_____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

PREVIOUS DENTIST_____

ADDRESS _____ EMAIL _____

PHONE _____ FAX _____

Please forward any previous radiographs and/or pertinent dental records by mail or email to:

GLEN LAKE DENTAL ASSOCIATES
14421 EXCELSIOR BLVD
MINNETONKA, MN 55345
(952) 935-5212

xray@glenlakedental.com

The expiration of this authorization is 1 year from the date of the signature by the Patient, Parent or Guardian. Patient may revoke at any time or date in writing.

Signature _____ Date _____

PLEASE MAIL OR FAX REQUEST TO PREVIOUS DENTIST PRIOR TO YOUR APPOINTMENT.