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:

Bates Dental, PS
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Spokane, WA 99223