



**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/St/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please forward any of the following information: x-rays, probing depth chart, charting and photographs to Dr. Evan Nelson at Nelson Dental in Wahpeton, ND.

I Hereby give you permission to release any and all of my dental records to Dr. Nelson.

\_\_\_\_\_

\_\_\_\_\_

Patient Signature (parent if a minor)

Date

Please email records to:

[smiles@nelsondentalnd.com](mailto:smiles@nelsondentalnd.com)