PACIFIC CREST DENTAL GROUP
PATIENT INFORMATION FORM

PACIFIC CREST
DENTAL GROUP

Dental Records Release Form

Patient Transferring: ____

Date of Birth: ____/_____/______ Telephone Number: (_____) ____________________

Current Address: ____

Transferring records out of Pacific Crest Dental Group to a new provider:

New provider’s name:

Address: ____

Office e-mail: ____

Transferring records to Pacific Crest Dental Group:

My previous dental provider’s information:

Dentist or Office Name: ____

Address: ____

Email (print clearly*) or phone contact:________________________________

Please send digital records to: office@pacificcrestdental.com

I hereby grant permission to **Pacific Crest Dental Group** to release or obtain information related to my dental/medical history, clinical notes and x- rays/photos to the above noted recipient.

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Patient Signature (parent if minor) **Date**