RIVER · PARK
FAMILY DENTISTRY

Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____ Phone Number: _____

Other Family Members to Transfer: _____

Previous Dentist/Practice Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth charting, charting and photographs to River Park Family Dentistry.

I hereby give you permission to release any and all of my dental records to Ben Grieb, DMD.

Patient/Legal Guardian Signature: _____ Date: _____

If records are digital, please email to:

info@riverparkfamilydentistry.com

Or mail to:

River Park Family Dentistry
155 SW Shevlin Hixon Drive
Bend, OR 97702