SMILE DESIGN

ELLSWORTH

AARON PALMER, DMD

Dental Records Release Form

Patient Name to Transfer:_____DOB:_____

Practice Name: _____
Address: _____
City/ State/ Zip: _____
Phone Number: _____fax: _____

Transfer to:

Smile Design Ellsworth

Aaron Palmer D.M.D
382 State Street
PO Box 611
Ellsworth ME 04605

I request the above name doctor to release the information specified below:

__ X- Rays, __Probing Depth Chart, __Charting __ photographs

Digital copies can be emailed to Malinda.SmileDesign@gmail.com

I hereby authorize release any and all of my dental records to Dr. Palmer.

_____ _____

Patient Signature (Parent if a Minor) Date