

Dental Records and X-Ray Transfer Authorization

Name of Patient: _____

Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, (Print Patient or Parent/Guardian Name) _____,
hereby authorize the release of dental records or knowledge concerning
the dental health of the patient(s) listed above. I further request that these
records be transferred to Dr. Ben White DDS at the address listed below.

Signed (Patient or Parent/Guardian Signature): _____

Date: _____

White Smiles General Dentistry
1108 N 12th Ave. Ste C, Pensacola, FL 32501
Phone: (850) 912-8877 | Fax: (850) 912-8932