Dr. Benjamin White, DDS

White Smiles General Dentistry

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
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