BFD

Buffalo Family Dentistry

106 Center Drive • Buffalo, MN 55313

(763) 682-6885 Fax: (763) 682-4534

Dear _____ Appointment Date_____

Please mail or fax this release form to your previous dental office, prior to you upcoming dental appointment.

REQUEST FOR RELEASE OF PATIENT RECORDS

Patient name_____ DOB_____

Family Members_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

Signature of Patient, Parent or Guardian:_____

**********To Be Completed By Previous Dentist**********

Patient of Record Since_____ Last Appointment_____

Periodontal: YES/NO Oral Surgery: YES/NO Endodontic: YES/NO

Prosthetic: YES/NO Orthodontic: YES/NO General Operative: YES/NO

Routine Maintenance: YES/NO Emergency/Infrequent Treatment: YES/NO

Incomplete Treatment:_____

Enclosures: BWS Dated:_____ Panorex Dated:_____

FMX Dated:_____ Other:_____

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Please send any records to: **Buffalo Family Dentistry** Email: **john@buffalofamilydentistry.com**

106 Center Drive

Buffalo, MN 55313

763-682-6885/Fax:763-682-4534

IF THERE ARE NO CURRENT RECORDS, PLEASE INDICATE SO AND FAX THIS FORM TO: 763-682-4534

We thank you in advance for your help and cooperation!

John C. Stangl, D.D.S.