wholelifedental
DENTISTRY WITH DIGNITY
301 Montague Ave. Greenwood, SC 29649 | Phone: 864.229.7092 | Fax: 864.223.1083

DENTAL RECORDS RELEASE FORM

Often times it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name_____ DOB_____

Previous Dentist Name_____

Address _____

City_____ State _____ Zip_____

I authorize Whole Life Dental LLC to request and receive any and all previous dental or medical charting as they pertain to the above named patients dental health and treatment.

_____ DOB _____/_____/_____
Print Name of patient or Legal Guardian

_____ _____
Signature of Patient or Legal Guardian Date

All patents over the age of 18 ***MUST*** sign their own forms. Patients under the age of age of 18 **CAN NOT** sign for themselves. ***ONLY*** a parent or a ***legal*** guardian may sign for a patient under the age of 18. (***Legal Guardian*** = you are the biological parent of the minor ***or*** you have been granted custody ***or*** guardianship over this minor by the courts.)

This consent will remain in effect for as long as I or my dependents are patients of record.

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