Records Request

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all you 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: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Previous Dentist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE SEND XRAYS TO JOHNPYKEDENTISTRY@GMAIL.COM

I authorize John Pyke Dentistry to request and receive any and all previous dental or medical charting as they pertain to the above named patient(s) dental health treatment.

_____ _____

Please **PRINT** your name Please **SIGN** your name

_____ _____

Date of Birth Today's Date

_____ _____

Signature of Legal Guardian (if applicable) Today's Date