Upwards Dental

Consent For Release of Dental Records

Patient Name:_____
DOB:_____

Name of Previous Dentist:_____
City and State of Previous Dentist:_____

I, _____, request that you please send the follow to Upwards Dental.

X	Most Recent Bitewings
X	Most Recent Full Mouth Series
X	Most Recent Pano

EMAIL IS PREFERABLE:
Hendersonville@UpwardsDental.com

If you are unable to send via email, please forward to the office address:

Upwards Dental
777 S. Allen Rd.
Flat Rock, NC 28731

Thank you for your attention in this matter.

Patient/Parent/Guardian's Signature:_____ Date: _____