Dental Record and Radiograph Release Form

If you would like x-rays transferred from another office, please fill out the bottom of this form and mail or fax it to **your previous dentist.** This will authorize them to duplicate your records. At your first visit with us, **x-rays will be taken** if we have not received them from your previous dentist.

Prior office name: _____

Phone number: _____ Fax number: _____

Email address: _____

Please send any current radiographs (BWX, FMX and/or PANO) perio charting and any other pertinent dental information to:

Cochell Family Dentistry, P.C.
2225 Mission Street SE, Suite #100
Salem, OR 97302
Phone: 503-585-8688
Fax: 503-763-8719
Email: frontdesk@cochellfd.com

Patients
Name:_____Birthdate:_____

Address:_____

City:_____ State:_____Zip:_____

_____ _____
Relationship to patient Today's Date

_____
Signature (parent if minor)

Note: My appointment at Cochell Family Dentistry, P.C. is on:_____
Please be sure the records arrive before the scheduled appointment above.

Thank you!