Aesthetic
Dental Center

Release of Dental Records and/or X-Rays Request

If you have been seen by another dentist within the last two years, please fill out the following information allowing Aesthetic Dental Center to obtain the applicable records.

Patient:_____ Date of Birth: _____

Dental Office/Doctor: _____

City, State, Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

I authorize the release of dental records and/or X-rays relevant to dental treatment and request that they be transferred to the dental office listed below:

Aesthetic Dental Clinic
Dr. Krysta Sellers
1207 W Divide Ave Suite 1
Bismarck, ND 58501
PH: (701)214-5552
FX: (701)214-5656
info@aestheticdentalbismarck.com

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient, Parent, or Guardian Date

For office Use Only:
Date of last exam:_____ Date of last cleaning: _____
Date of last X-rays: Panoramic:_____ Bitewings:_____