



PRINT THIS FORM AND RETURN IT TO PAW PAW FAMILY DENTISTRY

32800 E. Red Arrow Highway
PO Box 232
Paw Paw, MI 49079

EMAIL: PPFDesk@gmail.com
FAX: (269) 585-6077
PHONE: (269) 657-4001

INCOMING Dental Records Release Form (INDIVIDUAL)

Patient Name to transfer: _____

Date of Birth: _____ Phone Number: _____

Previous Dentist or Practice Name: _____

Previous Practice Phone#: _____ FAX: _____

Previous Practice Email: _____

- Patient Option #1
Return this completed form to Paw Paw Family Dentistry at least two weeks prior to your upcoming appointment and we will gladly contact your previous dentist for you.
- Patient Option #2
Give this completed form to your previous dental office at least two weeks prior to your upcoming appointment with us.

I hereby give permission to release any and all of my dental records to Paw Paw Family Dentistry.

Patient Name PRINTED: _____

Patient Signature: _____ Date: _____
(parent if a minor)

NOTE TO PATIENT:
Please have your previous dentist forward any current x-rays BEFORE your appointment. This is to save you money, because if we do not have your current x-rays on the day of your visit, we may need to take new ones, and that entire fee will be your responsibility. Insurance companies will not pay for x-rays twice if what they have on file is considered current.