PEDIATRIC DENTISTRY
AND BEYOND

RECORD RELEASE FORM

PLEASE FILL OUT AND SEND TO PREVIOUS DENTAL OFFICE.
IT WOULD GREATLY HELP US TO HAVE DENTAL RECORDS PRIOR TO DENTAL VISIT.

Date _____

To _____
(Doctor)

Address _____

City _____ State _____ Zip _____

I authorize the release of dental records, or copies of such, and request that they be transferred to:

Steven C. Demetriou, D.M.D. and Jasveen Singh, D.M.D.
1147 Main Street, #204 – Cottage Place
Tewksbury, MA 01876
(978) 851-6334

Please e-mail digital x-rays to info@pdbeyond.com

_____ _____
Please print your name (Parent/Guardian) Telephone Number

_____ _____
Parent/Guardian signature Date

_____ _____
Patient's Name Patient's Date of Birth