



designdentistry

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DESIGN DENTISTRY  
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To whom it may concern:

I give permission to release my X-rays to/ from Design Dentistry. Please email the most recent bitewings, PAs, and Pan X-rays to the given e-mail address. Please note date and provider applicable to the information sent.

Name of the previous Dentist's office: \_\_\_\_\_

Phone number: \_\_\_\_\_

Date of last Recall Exam/Hygiene: \_\_\_\_\_

Date of last PAN X-ray: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_  
Date