Please Release Records and X-rays for:

Patient Name: _____

Patient Date of Birth: _____

To be completed by last dentist:

Date of first visit to your office: _____

Date of last visit to your office: _____

Date of most current Bitewings: _____

Date of most current Pano/FMX: _____

Date of last Prophy: _____

Any fillings completed in last 2 years: _____

_____

Any bridges or crowns completed in last 10 years: _____

_____

Please send completed form and x-rays to:

Bob Koenitzer, DDS, Inc.
101 Lynch Creek Way
Petaluma, CA 94954
(707) 766-6666
Fax: (707) 763-1614
Email: DrKoenitzerDDS@gmail.com

Patient Signature: _____

Date: _____