V Family Dentistry
16427 W Little York Rd, Suite H
Houston, TX 77084

Phone: 281-201-6440 Fax: 281-819-7448

Dental Records Release Form

Patient Name to Transfer: ________________________
Date of Birth: _________________
Phone Number: _____________
Other Family Members to Transfer if applicable: ____________________________

Previous Dentist or Practice Name: ______________________
Address: __________________________
City, State, Zip: ___________________________
Phone Number: ____________________________

Please forward any of the following information that you have (circle):

X-rays PANO/FMX probing depth chart charting photographs

to V Family Dentistry

I hereby give you permission to release any and all of my dental records to V Family Dentistry

____________________________________ ________________
Patient Signature (parent if a minor) Date

If records are digital, please e-mail to: vfamilydentistrytx@gmail.com

Or mail to:
V Family Dentistry
16427 W Little York Rd, Suite H
Houston, TX 77084