Dental Records Release Form

Patient Name to transfer:

_____

Date of Birth: _____ Phone number: _____ _____

Other family members to transfer:

_____

Previous Dentist or Practice Name:

_____

Address:

_____

City/State/Zip :

_____

Phone number: _____ _____

Please forward any of the following information that you have:
X-rays, treatment records, treatment plans, and photographs to Kelli Junker DDS, Inc.

I hereby give permission to release any and all of my dental records to Dr. Junker.

_____ _____

Patient Signature (parent if a minor) Date

If records are digital, please email to:
info@kellijunkerdds.com

Or mail to:
Kelli Junker DDS
400 Newport Center Dr, #708
Newport Beach, CA 92660
(949)640-2970 tel
(949)640-2838 fax