Coastal Dental Associates

2837 Lafayette Road
Portsmouth, NH 03801
603-436-6997

Dental Records Release Form

Patient Transferring: ____

Date of Birth: _______/_______/_______ Telephone Number: (_____) _______________________

Current Address: ____

____

☐ **Transferring records into Coastal Dental Associates:**

My previous dental provider's information:

Dentist or Office Name: ____

Address: ____

Email (print clearly*):____

Phone:____________________________________ Fax:____________________________

Please send digital records to: info@coastaldentalassoc.com

______________________ ____ _____________

Printed Name Patient signature Date