

# 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/St/Zip : \_\_\_\_\_

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

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Joiner Family Dentistry.

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

\_\_\_\_\_  
Patient Signature (parent if a minor)

\_\_\_\_\_  
Date

If records are digital, please email to:

[dental@joinerdentistry.com](mailto:dental@joinerdentistry.com)

Or mail to:

Joiner Family Dentistry  
123 Albany Avenue SE  
PO Box 198  
Orange City, IA 51041