Dental Record History

Oftentimes it is necessary to obtain your complete dental history to devise a treatment plan that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name ____ DOB____________

Previous Dentist Name ____

Address ____

City ______________________________ State______________________ Zip__________

I authorize Bush Pediatric Dentistry to request and receive any and all previous dental charting and x-rays as they pertain to the above-named patient's dental health and treatment.

_____________________________________ _________________

Print Name of Legal Guardian DOB

_____________________________________ _________________

Signature of Legal Guardian Date

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