SCOTTSDALE SMILE CENTER
5410 North Scottsdale Road, Suite D-500 | Paradise Valley, Arizona 85253
(480) 991-2180 | info@scottsdalesmile.com | scottsdalesmile.com

RECORDS RELEASE

I authorize the following provider to release my dental records (including, but not limited to: bitewing radiographs taken within the last 12 months, FMX and/or panoramic radiographs taken within the last five years, periodontal charting recorded in the last 12 months, and any other pertinent information necessary to provide care) to Scottsdale Smile Center.

Our mutual patient has an appointment scheduled with our office _____. Please transfer all records as soon as possible to ensure that they are available prior to the patient's arrival.

Previous Dentist Information:

Name _____

Address _____

Phone _____

Email _____

Patient (print name) _____

Patient Signature _____

Date _____