hamamoto
DENTISTRY

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, probing depth chart, charting, and photographs to **Hamamoto Dentistry**

Email digital records to: info@hamamotodentistry.com

Mail: **22703 Bothell-Everett Hwy, Suite E**
Bothell, WA 98021
Phone: (425)821-1488 Fax: (425) 489-9997

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

Patient Signature (parent if a minor)

Date: