Uptown Dental
Mathias & Olson

642 Harrison Street
Port Townsend, WA 98368
Tel: (360) 385-4700 Fax: (360) 379-9730

Dental Records Request 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: _____

I hereby give you permission to release any and all of my dental records to Uptown Dental Clinic

Patient Signature (parent if a minor) **Date**

_____ _____

<u>To be completed by previous dental office</u>

Please forward any of the following information that you have (include all records 7 years old or less): x-rays, perio chart and charting to Uptown Dental Clinic.

Please provide dates of the following service:

Exam:	**Prophy:**	**How often?**
FMX:	**Perio Maintenance:**	**How often?**
PANO:	**Scaling:**	
BWX:	**Perio Chart:**	

If records are digital, please e-mail to: records@uptowndentalpt.com

Or mail to: **Uptown Dental Clinic**
642 Harrison Street
Port Townsend, WA 98368