8179 Cazenovia Road
Manlius, New York 13104
Office-315.682.2466
Fax-315.682.3914
office@drhendersondds.com

Release of Records

Patient(s) Name: _____ DOB_____

(Printed) _____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

Former or Future Dentist: (Circle One)**

Dentist Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

***FORMER DDS**: Please send any:*
Full mouth series of xrays (within 5 years)
Panoramic (within 3 years)
Bitewings (within 1 year)
Perio charting (within 3 years) & any history of SRP

Signature: _____

"Building relationships through comfort, service and technology"