PLEASE SEND THIS FORM TO YOUR PREVIOUS DENTAL PROVIDER

Dr. William Zugner & Dr. Todd R. Pedersen
55 North Ave
Webster, NY 14580
Phone (585) 872-2797 Fax (585) 872-5571

Date _____

Patient Name: _____
Patient DOB:_____

I, _____, am requesting the release of my dental records/x-rays.

Please forward these items to the following address:

Dr. William Zugner & Dr. Todd R. Pedersen

55 North Ave.

Webster, NY 14580

_____

Patient Signature: _____

Parent Signature: _____(If Patient is a Minor)

DATE OF MOST RECENT:
Bitewing x-rays_____ Full Mouth Xrays_____
Full mouth/panoramic_____