Dr. Nick I. Fleury's

CIRCLE DENTAL

THE DENTAL TEAM YOU KNOW AND TRUST

AUTHORIZATION TO RELASE HEALTHCARE INFORMATION

DATE: _____

PATIENT'S NAME: _____ DOB: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____ CELL: _____

INCLUDE FAMILY MEMBERS: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I REQUESTS AND AUTHORIZE (PREVIOUS DENTAL OFFICE):_____
ADDRESS: _____

TO RELEASE DENTAL RECORDS/TREATMENT NOTES, CURRENT RADIOGRAPHS (FMX EXPOSED WITHIN 5 YEARS & BWX WITHIN 18 MONTHS) AND PERIO CHARTING OF THE ABOVE NAMED PATIENT(S) TO:

Circle Dental
173 NH Route 104, Ste A
Meredith, NH 03264
DIGITAL RECORDS MAY BE EMAILED TO: Gina@CircleDentalNH.com

PLEASE INDICATE MOST RECENT DATES FOR THE FOLLOWING & RETURN THIS FORM TO US.

PROPHY_____TYPE_____
PERIO CHARTING_____
FMX_____
BITEWING X-RAYS_____
DOES THE PATIENT REQUIRE PREMED?_____

SIGNATURE OF AUTHORIZED PERSON: _____

173 NH Route 104, Suite A
Meredith, NH
03253

info@circledentalnh.com
Tel: (603) 515-4060
Fax: (603) 782-0868