STIRLING FAMILY DENTAL

7 Druid Avenue, Stirling. 5152
Phone 8339 1836 Fax 8339 2781
Email – reception@stirlingfamilydental.com.au

Dental Records Release Form

Name and address of patient records to Transfer:

_____

_____

Date of Birth: _____

Phone Number: _____

Other Family Members to Transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, patients records, and photographs to Stirling Family Dental

PLEASE EMAIL DIGITAL RADIOGRAPHS

I hereby give you permission to release any and all of my dental records to Stirling Family Dental

Patient Signature (parent if a minor) ……..Date …….

If records are digital, please e-mail to:
reception@stirlingfamilydental.com.au

Or mail to:
Stirling Family Dental
7 Druids Avenue,
Stirling. SA 5152