Patient Information (confidential)

Name _____ Date of Birth _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Previous Dentist/Dental Practice Information

Dentist/Dental Practice Name: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

Authorization

I hereby give you permission to release all of my dental records to Pacific Dental Care, PC. Please forward any of the following information that you have to Pacific Dental Care, PC: x-rays, perio charting, and/or any dental/orthodontic records.

_____ _____
Patient Signature (parent or legal guardian if patient is a minor) Date

If records are digital, please send via email to:

info@pacificdentalcarepc.com

Or postal mail to:

Pacific Dental Care, PC
1102 NE 82nd Ave
Portland, OR 97220

For additional information, please contact us at (503) 408-8927