L. BLAINE KENNINGTON, DDS

TO REQUEST/SEND RECORDS

Today's Date: ____________________

Previous Dental Office: ____
Address: ____
PH#: ___________________________________ Fax: _____________________________
Email: ____

Contact info:	Patient Information:
Cowlitz River Dental 358 Front Ave. NW Castle Rock, WA 98626 PH#: (360)274-9100 F: (360)274-8152 crdincr@gmail.com	☐ Pano (Most recent) ☐ BWX/FMX (Most recent) ☐ Perio Charting ☐ Other: ________________________ __________________________________ __________________________________

Patient Name: ______________________________________ D.O.B. ___________________
Patient Name: ______________________________________ D.O.B. ___________________
Patient Name: ______________________________________ D.O.B. ___________________
Patient Name: ______________________________________ D.O.B. ___________________

*The above named organization is authorized to release my records as indicated.

X
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Patient / Guardian Signature