SUNDANCE FAMILY DENTISTRY

5380 Stadium Parkway, Suite 119
Viera, Florida 32955
(321)837-3700
(855)208-2359

Dental Records Release

Full Name: _____ Birthdate: _____

Please add any additional family members and birthdates below:

Name:	Birthdate:
_____	_____
_____	_____
_____	_____
_____	_____

Dentist or practice name: _____

Address: _____

Phone number: _____

☐ My permission is granted to release complete information concerning the dental findings and treatments, including x-rays, periodontal probing chart, photographs, etc. to Sundance Family Dentistry

☐ My permission is granted to forward any x-rays and other information r egarding my dental health.

Please sign and fax back to our office at (855)208-2359.
Please email digital records to office@sundancedentistry.com.

Signature: _____ Date: _____