North Seattle Smiles
Family and Cosmetic Dentistry

RECORDS RELEASE AUTHORIZATION FORM

I authorize my dental records to be forwarded to North Seattle Smiles.

Patient Name (print): _____ DOB: _____

Patient Signature: _____ DATE: _____

Guardian Signature (if patient is a minor): _____

Name of Dental Clinic: _____

Dental Clinic Phone Number: _____

Please send the following information as digital images via email (preferable) or on photo quality paper:

- Full mouth series and panoramic x-rays taken within the past five years
- Bitewings and periapicals taken within the past two years
- Other: _____
_____

Please send to:
North Seattle Smiles
Dr. Julian Nguyen, DDS
Info@northseattlesmiles.com
907 North 130th Street
Seattle, WA 98113
Phone: 206-362-6116