X-RAY RELEASE FORM

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name _____ DOB ___/___/___

Previous Dentist Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

I authorize Rabine Family Dentistry to request and receive any and all previous dental or medical charting and x-rays as they pertain to the above name patients dental health and treatment.

_____ DOB ___/___/___

Print Name of patient or Legal Guardian

_____ ___/___/___

Signature of Patient or Legal Guardian Date

Please send x-ray's to hello@rabinedental.com in Dexis format if possible

Call the office at 203-375-1932 if you have any questions

All patients over the age of 18 **MUST** sign their own forms. Patients under the age of 18 **CAN NOT** sign for themselves. **ONLY** a parent or a **legal** guardian may sign for a patient under the age of 18.

This consent will remain in effect for as long as I or my dependents are patients of record.