DR. NEIL A. HOSS, D.M.D., LLC

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PATIENT TRANSFER / DENTAL RECORDS RELEASE

I hereby request and authorize the dental practice identified below to disclose and provide copies of my dental records to Dr. Neil A. Hoss, D.M.D., LLC.

PATIENT INFORMATION

Patient name: _____

Date of birth: _____

PREVIOUS DENTAL PRACTICE

Dentist / practice name: _____

Address: _____

Phone: _____

RECORDS REQUESTED

Please provide any and all clinical treatment records and information concerning my care, including personal patient information, medical and dental histories, examination records, radiographs (X-rays), clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and related materials.

Last prophylaxis: _____ Last bitewing X-rays (BWX): _____

Last panoramic X-ray (PANO): _____ Last full-mouth series (FMX): _____

Please email records and X-rays to: drhossdmd@gmail.com

I release the above-named person or entity from liability arising from compliance with this request and disclosure of the requested information, to the extent permitted by law.

Patient / parent / guardian signature: _____

Date: _____ Relationship (if applicable): _____