GINA M PICCIONI, DMD : JOHN G HARTMANN, DDS
344 LATHROP : RIVER FOREST, IL 60305
riverforestdental.com : 708.366.6760

Records Release/Request

To:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Email address:_____

If you have seen a specialist (for extraction, orthodontics, root canal or gum issues or anything else) in the past 3-5 years please list their contact information below. Failure to do so may result in insurance limitations being applied and charges you may be responsible for

Office name:_____
Phone #: _____ Work done:_____

I hereby authorize the release of my dental record or copies of such and request that they be transferred;

To:_____River Forest Dental Studio _____

Address:___344 Lathrop Ave._____

City:__River Forest_____State:___IL_____Zip:__60305_____

Phone:_(708)_366-6760_____Fax:_(708) _366-6762_____

Email address:___office@riverforestdental.com_____

_____
Print name of patient(s) DOB(s)

X-rays requested: _Pano or FMX (w/n 8yrs)_____BW (w/in 1.5 yr)_____
Date Date

Implants placed (Y/N)_____ IF Yes, provide letter on manufacturer & date placed
Crowns done (Y/N) _____ If yes, tooth #, date seated & material _____
4355 ever done (Y/N)_____ 4341 or 42 done (Y/N)_____-Dates/quads_____

X_____
Patient/Parent/Guardian Signature Date

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Initial