Dental Records Request Form

Patient Name to transfer: ____

Date of Birth: _____________________ Phone number: _____________________

Other family members to transfer: ____

Previous Dentist or Practice Name: ____

Address: ____

City/ST/Zip : ____

Phone number: __________________________

Please forward the following information: x-rays, treatment notes, periodontal charting, treatment plan, and intra-oral photographs to:

Barney Family Dental

14780 SW Osprey Dr. Suite200

Beaverton, OR 97007

Office (503) 579-2812, Fax (503) 579-6435

If records are digital, please email to: **info@barneydental.com**

I hereby give you permission to release any and all of my dental records/information to Barney Family Dental.

____ __________________

Patient/Guardian Signature Date