DBDentistry
111 N. Wabash Ave., Suite 1921
Chicago, Illinois 60602
Ph:312-332-4424
Fax: 312-332-4423

I,_____, DOB_____ am authorizing you and requesting that all of my dental records,

including, but not limited to, treatment records, medical information and radiographs be sent to:

DBDentistry

111 N. Wabash, Suite 1921

Chicago, IL 60602

It can also be sent via email to dbdentistry1@gmail.com

Signature: _____

Name of previous dentist_____

Phone number _____