IRWIN DENTAL CENTER

620 East 8th Street Port Angeles, WA 98362

360-457-0489 www.irwindentalcenter.com

To:_____

Address:_____City_____State_____Zip_____

Email Address:_____Phone_____

I authorize the release of dental records and request they be transferred to:

IRWIN DENTAL CENTER

appointments@irwindentalcenter.com

Fax: 360-452-3288

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Please print name of Patient, Parent or Guardian Relationship to Patient

Please forward this form to your previous Dentist prior to your appointment

To be completed by previous dental office.

Please provide the dates of the following services:

Exam: Scaling:

FMX/Pano: Perio Maintenance:

BWX: Prophy:

Additional comments/ info:

.KNOWLEDGE.PASSION.INTEGRITY.SERVICE.