POSTON DENTAL

In order to provide the best care possible, it is necessary that we acquire your records from your previous dentist. Please note, that if we do not receive your records prior to your first visit, we will need take x-rays to establish you as a new patient that may not be covered by your dental benefit plan. For this reason, we ask you to sign the release letter below that will be sent to your previous dentist.

Date: _____

Previous Dentist Name: _____ Email: _____

To whom it may concern:

Please forward requested records electronically to: smile@postondental.com

If unable to forward electronically, please mail to:

Poston Dental
801 E. 66th Street
Savannah, GA 31405
Fax: (912) 354-8504

Requested records include:

- Most recent full mouth series or panorex x-rays with date(s) taken.
- Most recent bitewing x-rays with date taken.
- Date of last preventative appointment and type.
    - Most recent periodontal charting
- Any history of periodontal procedures with dates.
- Implant, crown, or denture placement history with date(s) placed.
    - For Implants: Please include information with type, width, healing abutment, & serial number.

Thank you in advance for your time and consideration.

_____ _____

Print Patient Name Patient Date of Birth

_____

Patient Signature/Responsible Party Signature