Geelan
DENTAL CARE

5320 South Macadam Ave.
Ste. 100
Portland OR
97239

Patient Name:_____DOB:_____

Additional Family Members:_____

Name of previous dentist or dental clinic:_____

Location (city / state) of previous dentist:_____

Phone Number of dental office: _____

I authorize the release of my dental records, including my most recent BWX and FMX/Pano to Geelan Dental Care.

Please email my films to: info@geelandental.com
If digital films aren't available, please mail to the above address.

Patient Signature:_____Date:_____