5320 South Macadam Ave.
Ste. 100
Portland OR
97239

Patient Name:____DOB:___________________

Additional Family Members:____

Name of previous dentist/dental clinic: ____

Email address 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:_________________