New Patient Records Release & Request

New Patient to Salmon Brook Dental, LLC:_____
(Print Name)

Prior Dentist Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Email: _____

I hereby authorize the release of copies of my x-rays and treatment notes and request that they be transferred to:

Name of Dentist: **Kenneth Endres**
Salmon Brook Dental Assoc., LLC
Address: 35 Hartford Ave, P.O. 330
Granby, CT 06035

Phone: (860) 653-4551
Fax: (860) 653-4552
Email: salmonbrookdental@gmail.com

Patient's Signature: _____ Date: _____

Additional Notes: _____

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