Fanikos Salib Dental Care

Daniel Fanikos, DMD
Pediatric Dentist

Laurice Salib-Fanikos, DMD
General Dentist

Dental Records Release Form

Patient Name: ______________________________

Address: ______________________________

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Date of Birth: ______________ Phone Number: ______________

Previous Dentist

Dentist/Practice Name: ______________________________

Address: ______________________________

____

Phone Number: ______________

I, ______________________________ hereby give you permission, and request the release and transfer of any and all dental records for all of the individuals listed below, including, but not limited to, dental health status, treatment records, prescription records, reports, charts, health history, diagnostic casts and models, ALL radiographs (in JPG), impressions, and photographs (in JPG) to: Fanikos Salib Dental Associates, P.C. All materials should be emailed to the the following address:

needham@fsdentists.com woburn@fsdentists.com

______________________________ ______________

Patient/Parent Guardian Signature Date

Other Family Members to Transfer:

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ (patients over 18) Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ (patients over 18) Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ (patients over 18) Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ (patients over 18) Date: ______________

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p: 781.933.8380 f: 781.933.8381

905 Great Plain Avenue, Needham, MA 02492
p: 781.343.7447 f: 781.343.7448