Jay M. Epstein, DMD, P.C.
295 Western Avenue
Lynn, MA 01904
(781) 598-2100

I, _____, residing at

_____
authorize the release of a copy of my dental records and any information related to my health history, dental health status, treatment record and radiographs from:

Name: _____

Address: _____

_____
Patient's Signature

_____
Date

Please fill and return:

Last appointment _____
Last prophylaxis_____
Last X-rays:
Bite Wing_____
Full Series_____
Treatment Rendered
_____
Sealant application_____
Restorative_____
Orthodontic_____
Other_____

Attached:_____
Bitewings X-rays_____
Intraoral X-rays_____
Cephalometric_____
Diagnostic Cast_____

Comments:

* If a minor, parent or guardian must sign.