

Cindy Walker, DMD, PA.
Family Dentistry
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Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____

Phone number: _____

Other Family Members:

Previous Dentist Name and Address:

Please forward the most recent information that you have including:
radiographs, digital images, probing charts, summary of treatment, pending treatment.

**I hereby give permission to release any and all of my dental records to Dr.
Cindy Walker.**

Signed: _____ Date: _____