DR. MICHELLE SZASZ

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PREVIOUS DENTIST NAME OR DENTAL OFFICE NAME & LOCATION

_____

I AUTHORIZE YOU TO FURNISH ANY DENTAL RECORDS FOR (YOUR NAME)

_____DOB:_____

Any additional family members?

_____ _____

_____ _____

_____ _____

(YOUR PREVIOUS DENTIST WILL FILL OUT THE NEXT SECTION)

DATE OF LAST RECALL: _____

DATE OF LAST COMPLETE ORAL EXAM: _____

DATE OF LAST BITEWINGS: _____

DATE OF LAST PAN: _____

ANY OUTSTANDING TREATMENT: _____

Patient/Parent/Guardian Signature _____Date _____