PINE RIDGE DENTAL
5140 South 56th Street
8545 Executive Woods Drive
(402) 423-1100

Request for Dental Records

Patient's Name _____ Date of Birth _____

Dependents you're requesting records for:

Name_____ Date of Birth _____
Name_____ Date of Birth_____
Name_____ Date of Birth_____

I authorize you to release copies of my dental records and medical records relevant to dental treatment to Pine Ridge Dental.

Please send records via email to ew@pineridgedental.com

_____ _____
Signature/Parent/Guardian Date

Name of Previous Office: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax Number: _____

Email: _____