Ana R. Martinez, DDS
1187 Coast Village Road
Suite 11
Santa Barbara, CA 93108

phone 805. 617. 0686
fax 805. 617. 0612
www.rivierasmiles.com
smiles@rivierasmiles.com

Dental Record Release Form

Patient name to transfer:____

Date of birth:______________________________ Phone number:_______________________________

Other family members to transfer:____

Previous dentist or practice name:____

Address:____

City/State/Zip:_____________________________

Phone number:_____________________________

Please forward any of the following information that you have: X-rays, probing depth chart, dental charting and photographs to **Riviera Smiles**.

I hereby give you permission to release any and all of my dental records to Dr. Ana Martinez.

____ ___________________________________

Patient signature (parent if minor) Date

If records are digital, please email to: smile@rivierasmiles.com

or fax/mail to:

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