Transfer of Records to Willis Dental

The office of Dr. David Willis DMD, LLC
Brock Nelson, DMD
631 Jason Street NE, Suite 150
Salem, Oregon
Phone: 503-364-3004
Fax: 503-364-1623

I, ________________________________hereby request and give my permission to

____

to provide my information to Willis Dental, Dr. David Willis, DMD.

Patient name: ____DOB: ______________.

Patient or Guardian signature: _______________________________Date: _____________
Relationship to patient: ____.

Please email my records to: **office@willisdental.net**

Please indicate what is being requested, otherwise the most current x-rays will be transferred.

FMX:

BWX:

Pano:

Perio Chart:

Chart notes:

Your information will be transferred by digital transfer unless otherwise requested. Please allow up to 2 weeks from when information is received. A photocopy of this release will be as effective and valid as the original.

Thank you,

Willis Dental