The office of Dr. David G. Willis DMD, LLC
1261 Lancaster Drive NE Phone: 503 364 3004
Salem, OR 97301 Fax: 503 364 1623

TRANSFER DENTAL RECORDS

I, _____, hereby request and give

my permission to Dr. _____ to provide

Dr. David Willis of Willis Dental any and all information he/she request with respect to the dental treatment of:

Patient _____.

Patient Signature: _____ Date: _____
Parent, Legal Guardian or Custodian if the Patient is a minor.

Address: _____

City, State and Zip: _____

Please email records to:

Catherine.willisdental@gmail.com

FMX___

BWX___

Pano___