MCMASTER DENTAL, LLC
JENNIFER C. MCMASTER, D.M.D
108 S. Cleveland Street
Kershaw, SC 29067
803-475-9440
Fax: 803-475-3927

Dental Records Release Form

Patient Name To Transfer: ____

Date of Birth: ____________________ Phone Number: _____________________

Other Family Members To Transfer:

Name: ________________________DOB__________
Name: ________________________DOB__________
Name: ________________________DOB__________
Name: ________________________DOB__________

Previous Dentist or Practice Name: ______________________________________

Address: ____

City/State/Zip: ____

Phone Number: ______________________ Fax Number: _____________________

INFORMATION REQUESTED:

_____ Copy of Complete Dental Chart
_____ Copy of Dental X-Rays
_____ All Treatment Rendered
_____ Others (e.g. models)

PURPOSE OR NEED:

_____ Transfer of Records
_____ Second Opinion
_____ Other ____________
____

I hereby give you permission to release my dental records as requested above to Dr. Jennifer McMaster.

__________________________________ ____________________
Patient Signature (Parent If Minor Child) Date

If records are digital, please email to: McMaster.Dental108@gmail.com or mail to the above address.