403 East First Avenue
Shakopee, MN 55379
(952)445-5556
Fax: (952)445-3017
riverrockdds@gmail.com

X-RAY RELEASE FORM

Dentist Name: ____

E-mail Address: ____

Phone Number: _____________________ Fax Number:_________________

Address: ____

Please release dental records to RiverRock Dental for the following patient:

Name: _____________________________D.O.B._____________________

Patient Signature: ______________________ Date:_____________________

Please provide last date of service for:

Exam and Prophy: _________________ Fluoride Treatment:_____________

Bitewings: ______________________ Pano/FMX: ___________________