



642 Harrison Street
Port Townsend, WA 98368
Tel: (360) 385-4700 Fax: (360) 379-9730

Dental Records Request 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 (include all records 7 years old or less): x-rays, perio chart and charting to Uptown Dental Clinic.

I hereby give you permission to release any and all of my dental records to Uptown Dental Clinic

Patient Signature (parent if a minor)

Date

If records are digital, please e-mail to:

records.uptowndentalpt@olympus.net

Or mail to:

Uptown Dental Clinic
642 Harrison Street
Port Townsend, WA 98368