NEW LOOK DENTAL

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MEDICAL RELEASE REQUEST

To:_____

Address:_____

City: _____

Phone:_____

Fax:_____

Re. Patient: _____

The above named patient is in need of the following extensive dental treatment:

_____

Due to the patients medical history, a medical release is requested to perform the necessary dental treatment. Any special instructions or medicine for the above named patient:

_____

_____

Patient authorizes the release of the above information to the Doctor.

_____ _____

Signature (Patient or parent, if minor) Date

_____ _____

Doctor's Signature Date

Please signs anf return by fax.