X-ray Release Form

Date: _____

Patients Name: _____

Date of Birth: _____

Dentist Name: _____

Address: _____

_____

_____

Office Email Address: _____@_____

Office Phone Number: _____ - _____ - _____

Patient or Guardian Signature: _____ Date: _____

Print Name: _____

Dr. Geyman and Dr. Cranfills Office Use Only

FMX _____

PANO _____

BWX _____

PA's _____

Perio Charting _____

Last Oral Evaluation _____

Last Prophylaxis or Periodontal Maintenance _____