St. Pete Smiles
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727-343-0824
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Patient Name: ______________________________

Birth date:_______________ Social Security #:______________

I hereby authorize the release of all necessary dental records to:

Dr. name: _____________________________________
Dr. Address:____________________________________
City:__________ State:__________ Zip:__________
Dr. Ph:____
Dr. email:_______________________________________

Patient's Signature: ______________________________
(Parent if patient is a minor)

Patient Address:__________________________________

City:___________________State:__________Zip:______