Doroschak DENTAL

AUTHORIZATION X-RAY RELEASE FORM

Previous DDS: _____
Address: _____
Phone: _____

_____ Date of birth_____

_____ Date of birth_____

_____ Date of birth_____

To be sent to the office of:

DOROSCHAK DENTAL
230 BROADWAY STREET NE
MINNEAPOLIS, MN 55413
(612) 379-2300

Digital radiographs should be e mailed to: staff@doroschakdental.com

Signature: _____
Date: _____