Cori S. Hvideberg DMD, PA
General Dentistry

Dental Record History

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependents) behalf.

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Previous Dentist

Name_____Phone_____

Address_____

City_____ State _____ Zip_____

I authorize Hvideberg Dental (Cori S. Hvideberg, DMD, PA) to request and receive any and all previous dental or medical charting / x-rays as they pertain to the above named patients dental health and treatment.

_____ _____

Signature Date

Please Email records to frontdesk@hvidebergdental.com

1775 Arlington St. Suite 1
Sarasota, FL 34239

T 941 366 1775
F 941 366 1788

www.hvidebergdental.com