MAIN LINE
DENTAL CLUB

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 of your immediate and long term dental needs. This consent gives our office permission to obtain those records on your (or your dependent's) behalf.

Patient Name: _____DOB: _____

Previous Dentist Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____State: _____Zip Code: _____

I authorize Main Line Dental Club to request and receive any and all previous dental or medical charting as they pertain to the above named patient's dental health and treatment. Please email valid x-rays & records to Akpo@Dentify.com. Thank you.

_____ _____

Printed Name of Patient or Legal Guardian DOB

_____ _____

Signature of Patient of Legal Guardian Date

Main Line Dental Club

10 W. Lancaster Ave

Paoli, PA 19301

Office Phone: 610.644.5547

Office Fax: 610.644.1081

Office Email: concierge@mainlinedentalclub.com