Caceci Family Dentistry

Dr Paul J. Caceci D.D.S
Dr John P. Caceci D.D.S
Dr Matthew P. Caceci D.M.D.

CLINICAL AND RADIOGRAPHIC RECORDS RELEASE REQUEST

I _____, hereby authorize
(Patient Name)

_____ to provide my
(Previous Dentist and Phone #)
complete dental records including any bitewing or peri-apical radiographs taken in the last 2 years, as well as any full mouth series and panoramic radiographs taken in the last 5 years, to Caceci Family Dentistry.

I understand that the specific information requested includes a detailed report of examinations, treatment provided, radiographs and other information that pertains to me and my health. This consent is effective until such a date that I cancel this consent, and I understand the information released by this consent may be used after said date.

Please forward all requested information digitally to: **info@CaceciFamilyDentistry.com**

If you are not able to email, then kindly forward via mail to:
Caceci Family Dentistry
30 Bridge St (Suite 303)
New Milford, CT 06776

Office phone number: 860-354-9600

Thank you for your prompt response,

Patient Signature: _____ Date: _____

Patient Date of Birth: _____

Parent or Guardian Signature (if applicable): _____

Parent or Guardian Name: _____