Robert A. Chong, D.D.S., Inc.
460 Bush St., 2nd Floor, San Francisco, CA 94108
415-681-0668 | chongfamilydentistry@gmail.com

REQUEST FOR DENTAL RECORDS

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Previous Dental Office (Records to be sent from)

Office Name: _____

Office Address: _____

Office Phone: _____

Office Email: _____

I authorize the release of my complete dental records to Robert A. Chong, D.D.S., Inc.

Records may be sent via email (chongfamilydentistry@gmail.com) or U.S. Postal Service to the address above.

Signature: _____ Date: _____