

## Release of Dental Records

Previous Dentist: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Please release last FMX/PAN and BWX or any other relevant dental records to:**

Bryant family Dentistry

240 S Peters Rd, Ste 103

Knoxville, TN 37923

Fax: 865-531-8363

[Smile@BryantFamilyDentistryTN.com](mailto:Smile@BryantFamilyDentistryTN.com)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_