Seacoast Dream Dentistry
Lisa B. Schulman, DDS
200 Griffin Road, Suite 9
Portsmouth, NH 03801
Phone: (603)436-2951
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Patient Name:____ Patient DOB:______________________

Previous Dentist Name:____

Address:____

City:____________________________________ State:____________________ Zip Code:_________________

I authorize Seacoast Dream Dentistry to request and receive any and all previous dental and medical charting as they pertain to the named patient's dental health and treatment.

INFORMATION REQUESTED:

______ Copy of complete dental chart

______ Copy of dental x-rays

______ All treatment rendered

______ Other

Please email the requested information to seacoastdreamdentistry@comcast.net. Please contact our office with any questions you may have.

____ _______________________

Patient Name (Print) Date

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Signature