Brook West
Family Dentistry

Date:_____

I authorize the release of all current dental films and records to **Brook West Family Dentistry**. Please e-mail .jpg format files or mail films to the following:

Brook West Family Dentistry
Info@BrookWest.com (.jpg file format only)
7950 Main St N
Suite 205
Maple Grove, MN 55369

My Name: _____

First/last names and **dates of birth** for family members transferring to Brook West:

_____

_____

_____

Appointment(s) at Brook West Family Dentistry scheduled on: _____

If there are any questions, please contact me at (phone #):_____

Previous Dentist/Office Name: _____

Previous Dentist Phone #: _____ Fax #: _____

Previous Dentist/Office Email: _____

Thank you.

_____
(Your Signature)