



1147 Main Street
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RECORD RELEASE FORM

PLEASE FILL OUT AND SEND TO PREVIOUS DENTAL OFFICE.
IT WOULD GREATLY HELP US TO HAVE DENTAL RECORDS PRIOR TO DENTAL VISIT.

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To _____
(Doctor)

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City _____ State _____ Zip _____

I authorize the release of dental records, or copies of such, and request that they be transferred to:

Steven C. Demetriou, D.M.D.
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Tewksbury, MA 01876
(978) 851-6334

Please e-mail digital x-rays to info@drdemetriou.com

Please print your name (Parent/Guardian)

Telephone Number

Parent/Guardian signature

Date

Patient's Name

Patient's Date of Birth