KATE HAAVE, DDS, PC

Dr. ______________________________

Address ___________________________

____

Phone # ___________________________

Fax # _____________________________

I authorize the release and or transfer of my dental records, including all current x-rays and request that they be sent to Wilson Park Dental, who I have chosen to be my dentist of record.

E-Mail Address: info@wilsonparkdental.com
Fax Number: 605-343-3115

______________________________	______________________________
Patient Name	Patient Signature
______________________________	______________________________
Date of Birth	Date

WILSON PARK DENTAL
807 ST. ANDREW • RAPID CITY, SOUTH DAKOTA 57701 • (605) 343-9352 • WWW.WILSONPARKDENTAL.COM