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ORTHODONTICS

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Release of Records Requested by the Office of Dr. Jeffrey Crews and the following:

Patient's information

Name: _____

Address: _____

Phone: (____) _____ - _____

Email: _____

Former Dentist or Future Dentist: (Circle One)

Dentist Name: _____

Address: _____

Phone: (____) _____ - _____

Fax: (____) _____ - _____

Email: _____

Patient/Parent/Guardian Signature: _____

Date: _____ / _____ / _____