TACONIC DENTAL

Erin M Prunty DDS

Patient Name: _____

Date of Birth: _____

I hereby authorize my records to be released to Taconic Dental. Please include all x-rays taken within the past five years.

Previous Dentist Information

Name: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

_____

Signature

_____

Date

****Please email records when possible to: TaconicDental@gmail.com**

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