I, __________________________, hereby authorize the doctors and staff of Atlantic Oral Surgery Center to release records or knowledge concerning my dental health to the following doctors:

I was referred by: ____________________________ Promo Code: ___________________________

My general dentist is: ____

My dental specialist is: _______________________________________

My primary care physician is: __________________________________

My medical specialist is: ______________________________________

Name of pharmacy and town: ___________________________________

____

In case of an emergency, please contact:

Name: _________________________ Relationship to Patient: ___________________________

Address: ______________________________________

'"'______________________________________

Home phone: "__________________________________

Mobile phone: __________________________________

How can we contact you:

Home Phone:

Cell Phone:

E-mail:

Text Message:

Postal Mail:

Please bring a signed copy of this form with you on the day of your appointment or e-mail a copy ahead of time to info@AtlanticOralSurgery.com

Signed (patient or guardian name) ____

Printed name (patient or guardian name)____