THE FAMILY DENTISTRY GROUP OF NEW YORK

Records Release

Please fill this out and send to your previous dental office.

I hereby authorize the release of my dental records and my most recent dental x-rays to:

Please circle the office you would like your records sent to.

Saratoga Springs Family Dentistry
286 Church Street
Saratoga Springs, NY 12866
518-584-8150
SaratogaSprings@okrinse.com

Maple Ave Family Dentistry
425 Maple Ave
Saratoga Springs, NY 12866
518-587-3625
MapleAve@okrinse.com

Gloversville Family Dentistry
22 First Ave
Gloversville, NY 12078
518-725-1031
Gloversville@okrinse.com

Queensbury Family Dentistry
453 Dixon Rd Suite 5
Queensbury, NY 12804
518-792-1108
Queensbury@okrinse.com

Greenwich Family Dentistry
2651 State Route 40
Greenwich, NY 12834
518-692-9333
Greenwich@okrinse.com

Clifton Park Family Dentistry
983 Route 146
Clifton Park, NY 12065
518-371-3333
CliftonPark@okrinse.com

Columbia Family Dentistry
1654 Columbia Turnpike
Castleton-On-Hudson, NY 12033
518-477-8706
ColumbiaFamilyDentistry@okrinse.com

Lake George Family Dentistry
93 Montcalm St
Lake George, NY 12845
518-668-5457
LakeGeorge@okrinse.com

South Glens Falls Family Dentistry
63 Hudson Street
South Glens Falls, NY 12803
518-792-2187
SGF@okrinse.com

Previous Dental Provider: _____

E-mail: _____ **Phone:** _____ **Fax:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Additional Family Members: _____ **DOB:** _____

Additional Family Members: _____ **DOB:** _____