Name and Address of previous Dentist:

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I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Donald J. Farr, D.D.S, LTD.
2458 E. Russell Rd. # B
Las Vegas, NV 89120
Phone (702) 798-4595 Fax (702) 262-1115

Please email all DIAGNOSTIC X-RAYS
AND/OR RECORDS IN YOUR OFFICE to:

Email: info@donaldjfarrdds.com

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Patient's Name

____
Parent or Guardian's Name (if patient under 18 years of age)

Patient's Address: ______________________________

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Phone: ______________________________

______________________________ ______________
Signature *Date*