Champlin Family Dental .P.A.
A GENTLE APPROACH TO DENTISTRY

Please print your name and the name of any family members whose x-rays/records you want released:

Patient Name:
_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

Patient or Account Holder Signature_____Date:_____

Please send my/our current x-rays to:
_____
_____
_____ or email:_____
_____

To help us serve our patients better, if you are not planning on returning to the practice, please indicate why:

___Hours ____ Unhappy with clinic staff ____Change of Insurance
___Fees ____ Dissatisfied with treatment ____ Quality of customer service
___Billing ____ Moving out of area

___Other (Please describe here:
_____
_____
_____