ATLANTIC ORAL SURGERY CENTER, INC.

21 GILBERT ST NORTH. SUITE 210. TINTON FALLS, NJ 07701
732.747.0993

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

I was referred by: _____

My general dentist is: _____

My dental specialist is: _____

My primary care physician is: _____

My medical specialist is: _____

Name of pharmacy and town: _____

_____

You may also release records or knowledge concerning my dental health and treatment to: _____. Relationship to Patient: _____

In case of an emergency, please contact:

Name: _____

Relationship to Patient: _____

Address: _____

Home phone: _____

Mobile phone: _____

How can we contact you:	Yes	No
Home Phone:	____	____
Cell Phone:	____	____
E-mail:	____	____
Text Message:	____	____
Postal Mail:	____	____

Signed (patient or guardian name) _____

Printed name (patient or guardian name)_____