TO: ______________________________
(Dentist)

____
(Street)

____
(City/State/Zip)

____
(Phone)

I authorize my dental records, including x-rays (Full mouth/panorex and most recent bitewings), perio charting & treatment to be sent to:

Kenneth R Winokur, DMD
329 South Main Street
Independence, OR 97351

503-838-1633

Patient: ______________________ BD: ______________________

Signed: ______________________ Date: ______________________

Relationship: ______________________ Phone: ______________________

Street: ______________________

City/State/Zip: ______________________