paul e. coggins
DDS, MPH
welcome

Patient name _____
Last First Initial

Date _____ Date of birth _____

Previous Dentist or Practice Name: _____

Address: _____ City _____ State ____ Zip Code _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Dr. Paul Coggins, DDS, MPH, PA.

I hereby give you permission to release any and all of my dental records to Dr. Coggins.

Signature: _____ Date: _____
Patient Signature (parent if a minor)

Please mail records to:

Paul Coggins, DDS, MPH, PA
1203 Ridge Road
Raleigh NC 27607

Or email to:

info@paulcogginsdds.com

DENTAL RECORDS RELEASE FORM