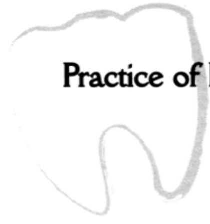

Marc F. Rubin, DMD PC
Teodora Silva, DMD
30 Main Street
Ashland, MA 01721
(508) 881-4266
(508) 881-3983 fax
www.AshlandDental.com

Request for transfer of Dental Records and Xrays

Patient Name: ________________________________ Date of Birth: _______________

I authorize the release of my personal information and dental x-rays to:

Marc F. Rubin, D.M.D.,P.C.
Teodora Silva, D.M.D.
30 Main Street Suite 2
Ashland, MA 01721
(508) 881-4266
(508) 881-3983 fax

***Please e-mail digital x-rays, in JPEG (.jpg) format to:
info@ashlanddental.com

Patient Signature: _________________________________ Date: ______________

Parent Signature: __________________________________
(If patient is a minor)

Additional Family Members:
Name Date of Birth

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