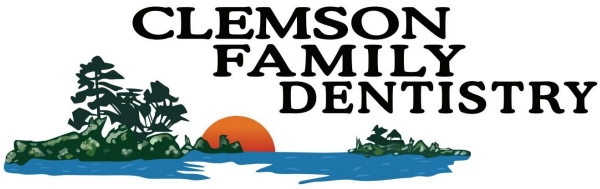

John G. McRoberts, DMD | Emily M. Ewoldt, DMD | Nathan J. Ewoldt, DMD

DENTAL RELEASE LETTER

DATE: _____

To Whom It May Concern:

I, _____, give my consent for Clemson Family Dentistry to receive any x-rays or information concerning my dental care. If possible, please email to admin@clemsondentist.com (only current bitewings or periapicals two years or less and full mouth and panoramic images five years or less).

Previous Dental Office Contact Information

Practice Name: _____

Dentist: _____

Phone Number: _____

City, State: _____

If you prefer, you may also mail to the following address:

CLEMSON FAMILY DENTISTRY
PO BOX 349
CLEMSON, SC 29633
PHONE: 864-654-5733

Please send records for the following family members listed:

Patient Signature: _____

Phone Number: _____