the littletooth company

PEDIATRIC DENTISTRY

Jason Leung, DMD
264A Queen Street
Southington, CT 06489
Ph (860) 426-2643
Fax (860)426-1029

140 Grandview Ave,
Suite 102
Waterbury CT 06708
Ph (203) 518-8250

I _____ authorize the release of my child(ren's) dental records
(Parent/Guardian Name)

From _____ **To** The Little Tooth Company
(Previous Dental Office)

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Please e-mail records and most recent radiographs (with dates obtained/taken) to **info@littletoothcompany.com**.

Please feel free to call with any questions at (860) 426-2643

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ **Date:** _____