LEVESQUE DENTISTRY
cosmetic • implant • restorative

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Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____

****I authorize the release of my dental records and x-rays to the facility listed below.****

This information may be disclosed to and used by the following organization: Levesque Dentistry 193 Kinsley Street Nashua, NH 03060

_____
Signature of patient or representative

_____
Date