RECORDS RELEASE TO DENTAL WELLNESS

Date _____

Dentist Name _____

Address _____

_____

_____

Please email a copy of the most recent radiographs and records to Dental Wellness.
Thank you in advance for your timely response to this letter.

Patients Name _____ DOB _____

Patient/Guardian Signature_____ Date_____

Please send to:

Dental Wellness
Devren Anderson, DDS
6104 S. Lyncrest Ave.
Sioux Falls, SD 57108
605.274.6191
605.274.6192 fax
ddwcenter@gmail.com