

Dr. Arima DDS PS  
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McCleary, WA.  
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EMAIL: Info1@smilesbyarima.comcastbiz.net

I hereby authorize (\*your previous Dentist name goes here) \_\_\_\_\_ to  
release information in the dental

Record of (\*your name DOB goes here) \_\_\_\_\_ DOB \_\_\_\_\_ also to  
include any and all Dental record/insurance/ financial information to Dr. Arima DDS PS.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Last full-mouth series \_\_\_\_\_

Last bitewing series \_\_\_\_\_

Last panoramic film \_\_\_\_\_

Last periodontal probing record last seen in our office: \_\_\_\_\_

Last prophylaxis or SRP: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_