Nicholas D. Doll, DMD, PC
1400 E Carroll St., Suite B
Macomb, IL 61455
(309)-421-3163

RELEASE OF DENTAL INFORMATION

I ________________________________ hereby authorize ________________________ to release my or my family's dental information, x-ray's, insurance information, and explanation thereof to Dr. Nicholas D. Doll, DMD.

A Photostat of this authorization will be valid as the original.

Name and DOB of patients:

_____________________________ _____________________________

_____________________________ _____________________________

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_____________________________ _____________________________

_____________________________ _____________________________

Signature of patient or guardian: ___________________________________

Date: _______________