



# Connections of Moorhead, Inc.

810 4<sup>th</sup> Ave. S., Suite 156, Moorhead, MN 56560

Phone: 218-233-8657 Fax: 218-236-5983

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## Dental Evaluation

Date of Examination: \_\_\_\_\_

Client: \_\_\_\_\_

Clients Date of Birth: \_\_\_\_\_

## Authorization to Release Information

I, \_\_\_\_\_,

(Client)

(Address)

give permission to \_\_\_\_\_ to provide and exchange information

(Dentist's Name)

regarding my examination with Connections – SILS for a period of 1 year.

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Assessment of Evaluation:

Treatment Provided:

Recommendations/Special Instructions:

Next Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Dentist's Name: (Printed) \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_