Oral Facial Health Care
Heidi F. Widoff, RDH, COM

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Agoura Hills, CA 91301
(818) 307-8518

Information and Release Form

		M F		
Patient's Name	Age		DOB	Today's date

Home Address	City	Zip	Home Phone	Cell

Patient's Occupation (School)	Employment (Grade)	Phone	Cell

E-mail Address_____ Fax_____

Spouse's Name	Occupation	Employment	Work Phone	Cell

If Minor

Father's Name	Occupation	Employment	Work Phone	Cell

Mother's Name	Occupation	Employment	Work Phone	Cell

Person responsible for this account	Relationship	If different address	Phone

Referred by	Address	Phone
Dentist's Name	Address	Phone
Orthodontist Name	Address	Phone
Physician's Name	Address	Phone

PATIENT RELEASE FORMS

I do hereby authorize provision of orofacial myofunctional therapy services as recommended for:

Name _____ **Date** _____ **Signature** _____

I Do [ ] I Do Not [ ] give my permission to have the records resulting from this evaluation or subsequent therapy sent to another party:

Date _____ **Signature** _____

I Do [ ] I Do Not [ ] hereby consent to the use of inter or extra oral photographs and video tape or any reproductions for diagnostic, documentary or educational purposes as associated with the therapy. I also consent to the use of my name in connection herewith.

Patient _____

Date _____ **Signature/Parent or Guardian** _____