

Pennino Family Dentistry, PC  
203 W Northwest HWY  
Barrington, IL 60010  
Phone: 847-381-6222  
Fax: 847-381-2916  
Email: info@pfdsmile.com

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

Dear Dr.: \_\_\_\_\_

I hereby authorize you to send all relevant x-rays taken at your office to Pennino Family Dentistry PC. This would include all BITEWING X-RAYS (taken within 18 months) and PANORAMIC OR FULL MOUTH SERIES (taken within 3 years)

Patient Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Additional Family Members: \_\_\_\_\_

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