Travis W. Wille, DDS, MS
651-464-1151

RECORDS PERMISSION FORM

I give permission for iSmile Orthodontics to perform diagnostic testing for the purpose of Orthodontic diagnosis and treatment planning, These diagnostic records may include x-rays, scans and photos. I understand I may request duplicate records for a duplication fee.

Patient Name: _____

Signature of patient or
Parent/Guardian:_____

Date:_____