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GENERAL AND COSMETIC DENTISTRY
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X-Ray/Dental Records Request Form

Patient's Name/DOB: _____

Family Members/DOB: _____

_____

_____

I am requesting that the following records be sent from:

Doctor: _____

Doctor's Address: _____

Doctor's Phone Number: _____

___ Full Mouth Radiographs and/or PAN (if taken within past 5 years)
___ Bitewings (if taken within past year)
___ Written chart notes

- Digital Radiographs may be emailed.
- Films may be duplicated and mailed to above address or photographed with digital camera and emailed.
- Written chart notes may be photocopied and sent to the above address, faxed, or photographed with digital camera and emailed.

Thank you,

Patient's Signature: _____ Date: _____