PLEASE FILL OUT AND MAIL TO PREVIOUS DENTIST

REQUEST FOR DENTAL RECORDS & TREATMENT

Patient Name: _____

Address: _____

Previous Treating Dentist: _____

Address: _____

Phone number: _____

Please forward diagnostic copies of radiographs from the previous 3 -5 years. Dates of most recent Panorex _____, FMX _____ and Bitewings_____.

Please also provide the following information to assist in the continued care of this patient.

1. Date of last exam and prophy _____ and how many month Recall _____.
2. Perio charting or perio recommendations and restorative concerns:

3. Any other considerations:

Your assistance in this matter will help us to make this transition much easier for your patient.

Thank you for your help.

_____

Patient Signature to Release Records