Patient Records Request

Name of Patient Whose Records are Requested_____

Date of Birth_____Phone:_____

Address:_____City/State/Zip_____

Please provide a copy of records as indicated below:

☐ The full dental record maintained by this provider/practice

☐ The dental record for the following time frame: _____through_____

☐ A specific section of the dental health record as described below:

☐ Copy of current x-rays and periodontal charting

Reason for request ☐ To continue care with another provider

☐ Legal purposes

Signature of Patient _____

Signature of Authorized Representative and Relationship_____

Name and phone number of previous dental provider_____

Date:_____