Request for Dental Records

To: Dr. _____

Tel: _____

Email: _____

Fax: _____

I _____, hereby request and authorize the release of my/my families dental records including all recent radiographs to Dr. Aram Mohajeri and his associates.

The radiographs should include original or copies of the most recent full mouth series, panoramic films and all films taken within the last 5 years. If they are digital, we prefer to receive them in digital format via email.

Family members to include: _____

Notes: Please indicate

1- Date of Initial Exam
2- Date of last recall
3-
4-

_____ _____

Patient/Guardian Signature Date

PRINT

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