PATIENT X-RAY/RECORDS REQUEST FORM

Dentist Name:________________________

Address:_____________________________

____

Phone: (___)__________________________

Name of Patient____

DOB:__________________________Phone: (___)_________________________

Address:____

Please provide a copy of my dental x-rays/records to:

Steven Prince, DMD
1218 Third Avenue, Suite 1300
Seattle, WA 98101
206.622.7237
info@stevenprincedmd.com
***Please send any digital x-rays as individual jpegs via e-mail.**

Signature of Patient:____

Signature of Authorized Personal Representative:__________________________

Relationship to Patient:____

Date:____________________