



REQUEST FOR COPIES OF DENTAL RECORDS

Date _____

Dentist Name _____

Address _____

Please send a copy of the most recent radiographs and records to our office.
Thank you in advance for your timely response to this request.

Patients Name _____ DOB _____

Address _____

Patient/Guardian Signature _____ Date _____

Sincerely,

Patient Services

American Dental Associates

P.O. Box 311

Gainesville, Virginia 20156

www.AmericanDental-Va.com

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