E-mail: office@armourdentistry.com

Phone: (267) 364-5117 Fax: (267) 364-5476

X-Ray/Dental Records Request Form

Patient's Name/DOB:
Family Members/DOB:

I am requesting that the following records be sent from:
Doctor:
Doctor's Address:
Doctor's Phone Number:
Full Mouth Radiographs and/or PAN (if taken within past 5 years)Bitewings (if taken within past year)Written chart notes
 Digital Radiographs may be emailed. Films may be duplicated and mailed to above address or photographed with digital camera and emailed. Written chart notes may be photocopied and sent to the above address, faxed, or photographed with digital camera and emailed.
Thank you,
Patient's Signature: Date: