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:_____