GENERAL DENTAL REQUEST FORM

Patient Request for Records Form

Date: _____

I _____ request that the records for

- o Myself- signature required
- o Any other family member under the age of 18
- o Any other family member over the age of 18-signature required by that person.

Please list the names and DOB of the persons records that you are requesting.

_____
_____
_____
_____

Please forward my records to the address below (either yourself or forwarding dentist.

Dr. Robert Nelson
168 US Route One
Falmouth, Maine 04105
Fax: 207-781-4232
Phone: 207-781-2448
Rhonda@perfectsmileme.com

Signature: _____ **Date:** _____