X-RAY REQUEST FORM

FROM:
St. Michael Dental Center
399 Central Ave E
PO Box 279
St. Michael, MN 55376
Phone: 763-497-2040
Fax: 763-497-4418
stmdental@hotmail.com

We have been asked to transfer your records to another office.

Please print the names of the patients whose records you would like copied and transferred.

_____ _____

_____ _____

_____ _____

Please circle option A or B.

A. Please send one year's of my X-Rays including photocopied print & duplicate x-rays at no charge.

B. Complete dental records, to be paid C.O.D. This option involves much more time and therefore you will be billed for the time & materials. MN State Statute recommends $10.00 plus $ .90 per page for photocopied pages, and $10.00 plus a fee per page for x-rays. Our fee per page for copied x-rays is $3.00. I understand Option B will cost at least $20.00 per person.

Signature (or parent if under 18) _____(Date)_____

Signature (or parent if under 18)_____ (Date)_____

Please forward x-rays to:
_____
_____
_____
_____
(Please include phone number)

To help us serve our patients better-please indicate why:

__ Hours of operation
__ Moving out of area
__ Change of insurance
__ Family scheduling conflicts
__ Billing problem
__ Other (please specify)_____

We will miss you and wish you the best in the future.

St. Michael Dental Center