XRAY REQUEST FORM

TO: _____

_____

_____

FROM: St. Michael Dental Center
399 Central Ave E
St. Michael, MN 55376
Phone: 763-497-2040
Fax: 763-497-4418
Email: xrays@stmichaeldental.com

The person(s) listed below has recently become a patient at our office and has requested that their dental records be forwarded to our office. Please forward any current x-rays to our office and provide dates of any FMX or Pano x-rays taken. Thank you.

Sincerely,
Dr. Jake Bromley
Dr. Dirk Posthumus
Dr. Laura Dill

Please list the names of al family members that are transferring:

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B. _____

_____ _____

Patient Signature (or parent if under 18) Date