X-RAY REQUEST FORM

To:_____
_____
_____
_____
_____

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

To Whom It May Concern:

The person(s) listed below have recently become a patient at our office and has asked that we request his/her previous dental records. By signing below, the patient is authorizing these records to be released to us. Please forward any current x-rays to our office and dates of previous x-rays, cleaning and exam.

_____
_____
_____
_____
_____

Thank you in advance for your prompt attention.

Sincerely,

Dirk Posthumus, DDS
Jake Bromley, DDS
Madeline Scheidt, DDS

_____

(Signature) (Date)