



Radiograph and Records Request Form

Date _____

Dentist Name _____
Address: _____
Phone: _____
Fax: _____

Dear Doctor and/or Office Administrator,

Please send a copy of the most recent radiographs and records to our office and fill out the requested information below. Thank you in advance for your timely response.

Patient's Name _____ DOB _____

Address _____

Patient/Guardian Signature _____ Date _____

Please fill in the date of the following:

Last oral examination	_____
Last polish and fluoride	_____
Bitewing radiographs	_____
Panorex radiograph	_____

Please mail these records to:

**Westmount Dental
8010 Bathurst Street, Unit C4
Thornhill, ON
L4J 0B8**

Sincerely,

Office Administration