REQUEST FOR DENTAL RECORDS*

DATE: ______________________________________

PATIENT: ___________________________________

I am requesting that a copy of my dental records be sent to: (circle Doctor):

Steven Hart, DDS
Devon Dental Associates
125 E. Swedesford Road
Suite 111
Wayne, Pa. 19087

Robert Rose, DMD
Devon Dental Associates
125 E. Swedesford Road
Suite 111
Wayne, Pa. 19087

******Please include copies of the most recent full mouth radiographs, bitewing radiographs, as well as pertinent progress notes and treatment plan notes.***

Thank you,

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Signature

***NOTE: Digital x-rays can be emailed to contact@devondental.com Please include the dates of the radiographs.**