



**REQUEST FOR DENTAL RECORDS\***

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

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

Robert Raymond, DMD  
Devon Pediatric Dentistry  
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](mailto:contact@devondental.com) Please include the dates of the radiographs.**