Dental Records Request

To Whom It May Concern:

Name: ____ DOB: ________________________

The patient above requests and authorizes the release of their radiographs to the office of Imagine Dentistry.

It is only necessary to send:

-Bitewing (BWX) radiographs, if less than one (1) year old.

-**Full Mouth Series (FMX)** films or **Panorex**, if less than five (5) years old.

-Clinical Notes

• Please forward diagnostic quality film copies by U.S Postal Mail to the address listed at the bottom of the page.

• Email digital radiographs and clinical notes to: **info@imaginedentistry.com**

I, ____, hereby request that copies of my dental radiographs, along with any pertinent treatment records, be forwarded to Imagine Dentistry.

Patient Signature: ______________________________________ Date: _______________________

***We must have your current x-rays or you will be charged for an updated set of x-rays.**

**Previous Dental Office ____

**My appointment @ Imagine Dentistry is on _________. Please be sure my records arrive before then.

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