Advance Family & Cosmetic Dentistry

410-682-3800

RECORDS REQUEST

From Dental Office ______________________

Dental Office Phone #____________________

Patient Name __________________________

Date of birth __________________

Phone________________________

I authorize the request of dental records/xrays or

copies of such to be forwarded by email to:

advancemysmile@gmail.com

Patient Signature____________________

Guardian Signature __________________

Date ________________