

Dr. Bob Adler, D.D.S.
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REQUEST FOR RECORDS

Date: _____

To Dr. _____

In accordance with the following patient's wishes, please forward any of the following items you have on file for:

_____ Patient Name _____ Date of Birth

- Radiographs
- Charting of existing oral/dental conditions
- Patient's treatment history
- Correspondence from any specialists

We thank you in advance for your prompt assistance.

Patient Signature _____ Date

Witness Signature _____ Date