

Parkside Dental Health

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**Request for Dental Records**

To Whom It May Concern:

Please send my dental records information to the office listed above.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Information requested: \_\_\_\_\_

Signature:

Print Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Signature of Patient Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_