Perfect Smiles dental care

8650 Candlelight Lane, Suite One, Lenexa, KS 66215
(913) 631-2677

Request for Radiographs/Records

Dear Doctor _____:

Please forward your most recent radiographs and records on the following patient (duplicates are acceptable) original radiographs will not be returned. The patient has given permission to release records and radiographs from your office with his/her signature (patient, parent or guardian) below. Please forward to the address above or you may e-mail to: PerfectSmilesDC@gmail.com.

Patient Name: _____
(Print Name)

Patient DOB: _____

Patient Address: _____

_____

_____
(City/State/Zip)

Signature: _____
(Patient/Parent or Guardian)

Date of Request: _____

Radiographs Requested (Circle all that apply):

FMX BWX PANORAMIC OCCLUSAL

Staff Signature: _____
(Perfect Smiles Dental Care)

Additional Comments: