

PLEASE MAIL THIS FORM TO YOUR PREVIOUS DENTIST

RECORDS REQUEST:

Dear Dr. _____,

Please forward dental records, including bitewing x-rays (less than 18mos. old) and fmx/panorex (less than 5 yrs old) for myself/my family, including the following persons:

to the following address:

**West Springfield Dental Arts
6116 Rolling Rd.
Suite 316
Springfield, VA 22152
(703) 451-8332 fax(703)451-4661**

or email: mydentist@wsdentalarts.com

If you have any questions, I can be reached at this phone number: _____

Thank you for your prompt cooperation.

Sincerely,
