Request for Dental Records

Parents, please fill out highlighted area and mail to previous dentist.

Patient(s) name:_____

Patient(s) Date of Birth:_____

Address:_____

Dentist to be contacted for previous records:_____

Address:_____

Please forward the following copies of radiographs from the previous three years.

Panorex: _____

Bitewings: _____

Periapical or occlusal: _____

Please also provide the following to assist in the continued care of this patient:

Date of:

Last Exam and prophylaxis:_____

Last Fluoride treatment: _____

Frequency of Recall: _____

Has orthodontic treatment been recommended for this patient? Yes No

Has this patient been prescribed a fluoride supplement? Yes No

Are there any special dental concerns or considerations for this patient?_____

_____

_____

Thank you,

_____ _____

Parent/Guardian Signature of Minor Child Date

Please mail records to:

Christine S. Scott, DDS, PC
5507 Chamblee Dunwoody Road
Dunwoody, GA 30338
770-396-4300
Diplomate of the American Board of Pediatric Dentistry