



# DRS. KEARNS, ASHBY, RAJCHEL & ASSOCIATES

DENTISTRY FOR INFANTS, CHILDREN & TEENS

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## REQUEST FOR DENTAL RECORDS

I, \_\_\_\_\_, am requesting copies of dental  
Parent/Guardian of Minor Child or Self

radiographs and/or dental records for the following patient(s).

Patient name(s): \_\_\_\_\_

Patient(s) Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Would you like all future scheduled appointments canceled? \_\_\_\_\_ Yes \_\_\_\_\_ No

I would like copies of the records to be sent to the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian of Minor Child or Self Signature

Date Received: \_\_\_\_\_  
(Office Use Only)