Patient X-ray/Records Request Form

Dentist/Clinic: (Previous Dentist/Clinic Name)

Address:

Phone #:

Name of Patient:

Date of Birth:

Address:

Phone #:

Please provide a copy of my dental x-rays (bitewings, periapicals, FMX/Panorex) as well as any specified records as requested to:

Byron Dental Group
21 Frontage Rd NE
Byron, MN 55920
p 507-775-6445
f 507-775-6445
appointments@byrondental.net
*Please send any digital x-rays as individual JPEG files via email

Patient Signature: X _____

Signature of Authorized Representative: X _____

Relationship to patient:

Date: