SONGBIRD DENTAL

Request of Dental Radiographs and Records

Date of request: _____

Previous Dental Office: _____

Address: _____

Phone Number: _____ Fax: _____

Email: _____

Patients Name: _____ Patients D.O.B: _____

Patients Name: _____ Patients D.O.B: _____

Patients Name: _____ Patients D.O.B: _____

Please email records to:

office@songbirddental.com

or send printed records to:

Songbird Dental

235 Main St. Unit 2

Shrewsbury, MA 01545

By my signature below, I authorize my records to be released to Songbird Dental at the above email, and/or address listed.

Signature (patient, parent, or legal guardian): _____

Print Name (patient, parent, or legal guardian): _____