Date: _____

To _____,
Dr's name & office

I, _____ of _____
Name Address

_____, request that copies of the most recent full mouth series,

panoramic radiographs and/or bitewings taken in your office be:

____ given to me.

____ sent to me at the following address:

_____

____ forwarded to the following dental office:

Northwood Dental Associates
3023 Eastland Blvd.,
Suite 112
Clearwater, FL 33761

____ if digital, please e-mail to reception@northwood-dental.com

Thank you,

_____

Patient Signature