**The Smile Zone**

**576 Sand Creek Road**

**Albany, New York 12205**

**Phone (518) 869-5348**

**Fax (518 869-0417**

**Request for Dental Records and X-Rays**

Please complete form and mail to your previous Dentist.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name of previous Dentist)**

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

 **(Address of previous Dentist)**

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

 **(City, State, Zip Code)**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of previous Dentist)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize and request that you

 (Name of Patient) forward my dental records and X-rays to:

**The Smile Zone**

**576 Sand Creek Road**

**Albany, New York 12205**

Patient Signature