Dental Records Request

* Please send this to your previous dentist at least two weeks before your scheduled appointment with our office.

*We must have your current x-rays or you will be charged for an updated set of x-rays.

To Whom It May Concern:

Name: _____ DOB: _____

The patient above requests and authorizes the release of their radiographs to the office of

Grand Marais Family Dentistry.

It is only necessary to send:

-Bitewing (BWX) radiographs, if less than one (1) year old.

-Full Mouth Series (FMX) films or Panorex, if less than five (5) years old.

• Please forward diagnostic quality film copies by U.S Postal Mail to:

Grand Marais Family Dentistry
PO BOX 670
GRAND MARAIS MINNESOTA 55604

• Email digital radiographs to: info@grandmaraisfamilydentistry.com

I, _____, hereby request that copies of my dental radiographs, along with any pertinent treatment records, be forwarded to Imagine Dentistry.