CEDAR CREST DENTAL CARE

1251 S. Cedar Crest Blvd., Suite 207C | Allentown, PA 18103 | (610) 437-9000

Request for X-rays and Dental Records

COMPLETE THIS BEFORE YOUR APPOINTMENT

Print clearly, complete and sign this form, and bring it to Cedar Crest Dental Care when you come in. If no X-rays are received by your appointment, you may be responsible for the cost of current X-rays.

1. PREVIOUS DENTAL OFFICE

Dentist or practice name

Fax

Email

2. PATIENT INFORMATION

Patient's full name

Date of birth

Date of request

Also include records for (list each additional patient name and date of birth)

3. AUTHORIZATION

Please transfer my dental records and X-rays, especially panoramic or full-mouth X-rays taken within the last five years and bitewings taken within the past two years, to:

Cedar Crest Dental Care

1251 S. Cedar Crest Blvd., Suite 207C, Allentown, PA 18103

Digital records: info@ccdc.dentist

☐ I authorize the previous dental office named above to transfer the listed records and X-rays to Cedar Crest Dental Care.

Patient or legal representative signature

Date signed

Printed name

Relationship to patient (if applicable)

BRING THIS COMPLETED AND SIGNED FORM TO YOUR APPOINTMENT.

Questions? Call (610) 437-9000 or email info@ccdc.dentist.