NEWTOWN DENTAL ARTS
UNCOMPROMISING STANDARDS. EXQUISITE RESULTS.

12 Penns Trail ▪ Suite B ▪ Newtown PA 18940
Tel: 215.860.4141 ▪ Fax: 215.860.6070 ▪ Email: Records@NewtownDentalArts.com

X-Ray/Dental Records Request Form

Patient's Name/DOB: _____

Family Members'/DOB: _____

_____

_____

I am requesting that the following records be sent to Newtown Dental Arts from:

Doctor: _____

Doctor's Address: _____

Doctor's Phone Number: _____ Doctor's Fax Number: _____

___ Full Mouth Radiographs and/or PAN (if taken within past 5 years)

___ Bitewings (if taken within past two years)

___ Progress Notes / Treatment History (or written chart notes)

- Digital Radiographs may be emailed in **.jpeg, .jpg or .dex format**.
- Films may be duplicated and mailed to above address or scanned / photographed and emailed.
- Written chart notes may be photocopied and sent to the above address, faxed or scanned / photographed and emailed.

Thank you,

Patient or Guardian Signature: _____ Date: _____