To Whom It May Concern:

We are requesting any dental records, including films, on behalf of the below named patient/s and/or parents, or legal guardians. We thank your for your time and prompt attention to this matter.

Pt.'s
Name/s____DOB____________________

Pt.'s
Name/s____DOB____________________

Pt.'s
Name/s____DOB____________________

Pt.'s
Name/s____DOB____________________

____
(Signature of Patient/Legal Guardian) (Date)

Please send to:
Chestnut Family and Cosmetic Dentistry
1013 Chestnut Lane, Suite 230
Matthews, NC 28104
704 684 0447
704 684 1334 (fax)