# Hanna & Mazer Dental Group

## RECORDS REQUEST

Previous Dental Office: ____________________________________________________

Previous Dentist's Name: __________________________________________________

Street Address: _________________________________________________________

City: ______________________________________ State: _____________________

Phone Number: _________________________ Fax Number: ______________________

**PLEASE RELEASE RECORDS TO OUR OFFICE FOR THE FOLLOWING PATIENT:**

Patient's Name: ______________________________ Date of Birth: ________________

Street Address: _________________________________________________________

City: _______________________________________ State: ____________________

Additional Family Members: _________________________________________________

**Please e-mail copies of any X-rays to: HannaAndMazerDental@yahoo.com**

Date of Last Prophylaxis and Oral Exam: ____ /____ /______

Date of Last X-rays: (Bitewings): ____ /____ /______ (FMX or Panorex): ____ /____ /______

_____________________________________________________________________________

**Patient, Parent or Guardian Signature** **Date**

61 Fourth Street | Stamford, CT 06905
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