

# Poulsbo Dental Center

19170 8<sup>th</sup> Avenue NE

Poulsbo, WA 98370

## PATIENT RECORDS REQUEST FORM

Name of Patient Whose Record is requested: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

### Please provide a copy of the record as indicated below:

\_\_\_ Bite Wing X-rays within the last 24 months (Date: \_\_\_\_\_)

\_\_\_ Full Mouth Series and / or Panoramic X-rays within the last 60 months (Date: \_\_\_\_\_)

\_\_\_ Perio Chart (Date: \_\_\_\_\_)

\_\_\_ Date of most recent exam and cleaning \_\_\_\_\_ Adult Prophylaxis or PM?

\_\_\_ Any history of Periodontal (RPC?) Y/N Dates: UR: \_\_\_\_\_, LR: \_\_\_\_\_, UL: \_\_\_\_\_, LL: \_\_\_\_\_  
Therapy

\_\_\_ Other \_\_\_\_\_

**Transfer from:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Transfer to:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Or Signature of Authorized Personal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Poulsbo Dental Center

19170 8<sup>th</sup> Avenue NE

Poulsbo, WA 98370

**Phone:** 360 - 779 -3633

**Fax:** 360 - 779 -6232

**Email:** office@poulsbodentalcenter.net