Tsar Dental Excellence

Cosmetic
Restorative
Neuromuscular Dentistry

PATIENT RECORD REQUEST FORM

PLEASE CHECK REQUESTED RECORDS:

___ PATIENT'S INFO ___PATIENT'S NOTES___PATIENT'S XRAYS___ PATIENT'S MED HISTORY

PATIENT NAME_____

DATE OF BIRTH_____/_____/_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

PHONE (_____**)**_____ **CELL (**_____**)**_____

SIGNATURE _____ **DATE**_____

RECORD RELEASE FROM:

DR'S NAME_____

DR'S ADDRESS_____

DR'S PHONE (_____**)**_____ **FAX (**_____**)**_____

DR'S E-MAIL_____**@**_____**.COM**

RECORD RELEASE TO:

TSAR DENTAL EXCELLENCE, NATALIA TSAR, DDS, LVIF

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E-MAIL: **TSARDENTALEXCELLENCE@GMAIL.COM**

PLEASE EMAIL THE RECORDS IF THEY ARE DIGITAL, THANK YOU