Records Request

Date:_____

Name & Address of Previous Dentist:_____

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Please send records to: **Chanhassen Dental**
PO Box 189
Chanhassen, Mn. 55317
Email: office@chanhassendental.com
952-934-3383 phone
952-934-6668 fax

_____has requested that I review his/her dental records. Please send current radiographs and any other pertinent information regarding patient care. Please enclose any treatment completed (ext. & fillings) and date of service completed. Thank you.

Sincerely,

_____

Jeffrey R. Hall DDS
Bradley D. Lembke DDS

I request the release of my dental records to Chanhassen Dental.

_____
Patient Signature
Patient Date of Birth:_____