1235 Indian Trail Road
Suite 300 Norcross, GA 30093
Tel: 770-837-9431

Parent Name, Address and Tel: _____

_____

_____

Name and Date of Birth/s of the patient/patients:

1._____

2._____

3._____

I am writing to request a copy of the dental records for my child/children listed above to be sent to the office of:
Office Name and Address: Please include their email and fax number

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____