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PATIENT X-RAYS REQUEST FORM

X-ray Request for (Print Patient Name):_____

Patient DOB:____ _____

Patient Phone:_____ _____

Send EMAIL to:_____ _____

Address:_____ _____

Please provide a copy of:

- ☐ Full Mouth X-ray
- ☐ Panoramic Film
- ☐ Bitewings
- ☐ Patient History (Ledger)

Reason:__ _____

_____

_____

Requestor Name (Please Print):____ _____

Requestor Signature:_____ _____

Requestor's Relationship to Patient (Self/Parent/Guardian/Etc):_____ _____

Date:_____ _____

Send Form