REQUEST FOR TRANSER OF PATIENT RECORDS

I hereby request that a copy of my dental and/or medical records be sent to Hogan Family Dental. Please be sure to include any and all X-rays, history of procedures, clinical notes, and any other relevant records (i.e. dates of scaling and root planing procedures).

Patient's Name (Printed): _____

Patient's Date of Birth: _____

Name of Parent/Guardian: _____

Relationship to Patient: _____

Previous Dentist(s): _____

The patient agrees hereby to cover the cost of copying or transferring said records and x-rays.

Patient / Guardian Signature: _____

Witness to Signature: _____

Date of Request: _____

NOTES: _____

_____

_____

Please send physical or digital records to:

Hogan Family Dental
1820 Valley Drive East
Miles City MT 59301

T: (406) 234 – 2926
F: (406) 234 – 3552
E: hfdental@midrivers.com

Please feel free to contact Hogan Family Dental with any questions you may have.
Thank you in advance for your prompt reply.