

Record Request Form

I _____, hereby request that
Parent or legal guardian name

ALL dental records for _____
Name of child or children

From: _____
Previous Dentist Name or Practice Name

Address: _____

Phone Number: _____

Be forwarded to: Please circle which address you would like them to be sent to

*Kiddsmiles
1201 Northern Blvd
Suite 102
Manhasset, NY 11030
Tel: 516-365-5439
Fax: 516-365-5469*

*Kiddsmiles
1476 Deer Park Ave
Suite 2
North Babylon, NY 11703
Tel: 631-254-5437
Fax: 631-940-5943*

Thank you,

Signature of parent or legal guardian