SAUTTER
FAMILY DENTISTRY

DENTAL RECORDS REQUEST

Please send this to your previous dentist at least two weeks BEFORE your scheduled appointment with our office.

*We must have your current x-rays or you will be charged for an updated set of xrays.

To Whom It May Concern: _____
(Name of Previous Office/Dentist)

Name :_____ DOB: _____

The patient above requests and authorizes the release of their radiographs to the office of Barry M. Sautter, DDS at **Sautter Family Dentistry**.

It is only necessary to send:

- Bitewing (BWX) radiographs, if less than one (1) year old.
- Full Mouth Series (FMX) films or Panorex (PAN), if less than five (5) years old.
  - ❖ Please email digital radiographs to: xrays@sautterfamilydentistry.com
  - ❖ **Our office uses Dexis Imaging**

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian (if Patient is a Minor) Date

Sautter Family Dentistry
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