LAKE PLACID™
FAMILY DENTAL
DAVID BALESTRINI, DMD

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(518) 523-2406
(518) 523-3045(fax)

Record Request Form

Date: _____

To: _____

Phone: _____ Fax: _____

Address: _____

Please release a copy of my dental records, including copies of my most recent radiographs (full mouth series or panorex, and bitewings) to Dr. Balestrini.
Whenever possible, digital radiographs should be sent in jpeg format to: scheduling@lakeplacidsmiles.com

_____
Patient name(s) (Please print)

_____
Patient date(s) of birth

_____
Patient signature

For patients under the age of 18:

Parent or legal guardian name (please print) _____

Parent/guardian signature: _____