CHESTNUT DENTAL
YOUR SMILE'S IN GREAT HANDS

Request for Dental Records

Patient Information:

Name: _____ Date of Birth: _____

Address: _____Phone: _____

Records Requested:

Reason for Request (if insurance please specify new type): _____

(Request will be valid for 90 days and may be revoked any time prior to the expiration date)

Records to be sent to:

Encrypted email: _____@_____

Patient(18 or over)/Guardian - Signature: _____Date: _____

If guardian relationship to patient: _____

Please send your requests to the office email listed below.

Please contact us if you have any questions about your request.

Needham patients - Dentists@chestnutdental.com – tel. 781-444-6650

Franklin patients – chartsfranklin@chestnutdental.com – tel. 508-520-6660

Bedford patients – chartsbedford@chestnutdental.com – tel. 339-234-5075

For office use only

Records sent by – Name (CDA Staff): _____Date: _____
