263 Route 108
Somersworth, NH 03878
Phone: (603) 692-9229
Fax: (603) 692-5850
Digital x-rays (in jpeg format) send to
info@keystonedentalarts.com

TO: ____
(Fill in previous dentist name and address)

Patient Name __________________________ DOB _____________

I request that a copy of my treatment notes and original x-rays be sent to:

Keystone Dental Arts
Robert Christian, DDS
263 Route 108
Somersworth NH 03878

By ___________________________ (Date of first appointment)

If applicable, please forward all information for the following family members:

_______________________ Name _______________________ DOB

_______________________ Name _______________________ DOB

_______________________ Name _______________________ DOB

__________________________________ ________________
Patient Signature Date

Thank you for your prompt attention to my request. If x-rays are not received in our office at the time of your examination, we may need to take them again at **additional cost to you,** the patient.

Mail/fax this completed form to your previous dentist