

Janis Moriarty, D.M.D.
General Dentistry
607 Main Street * Winchester, MA 01890
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X-ray & Dental History Request Form

To our patient:

Please mail or fax this completed form to your previous dentist giving them permission to release your records and x-rays to our office. Please check if they charge a fee for this transaction as this would be your responsibility.

Previous dentist information:

Name: _____

Address: _____

Phone #'s V: () _____ ~ _____ Fax: () _____ ~ _____

To Whom It May Concern:

Please forward all radiographs and dental history, which you have on file per request of our patient.

Mailing Address:
Janis Moriarty, DMD, PC
607 Main Street
Winchester, MA 01890

OR

E-mail Address: (for digital x-rays)
mydentalpractice@verizon.net

PLEASE e-mail digital x-rays in JPEG format ONLY. Thank you.

If you have special requirements to obtain the requested information, please contact the patient or our office so we can notify the patient.

Your prompt attention to this matter would be greatly appreciated.

Thank you ,
The Office of Janis Moriarty, DMD

Patient(s) – Print Name _____

Patient(s) -Date of Birth _____

Patient Signature