Belknap Dental Associates
40 Chestnut Street, Suite 2
Dover, NH 03820
Telephone: (603) 742-4735
Fax: (603) 742-9911
www.belknapdental .com

Date: _____

Dear Dr. _____

I/We intend on becoming regular patient(s) of Belknap Dental Associates:

Patient Name(s): _____ Date of Birth:_____

_____ Date of Birth:_____

_____ Date of Birth:_____

_____ Date of Birth:_____

Please send current x-rays (within 5 years) along with any other records you may feel are pertinent to:

Belknap Dental Associates
40 Chestnut Street, Suite 2
Dover, NH 03820

If you are able to e-mail digital images, please send to:

xrays@belknapdental.com

I hereby authorize and request the release of my radiographs/records.

Patient Signature: _____ Date:_____