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

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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:_____