Alvin C. Matthews, DDS, PC
FAMILY & COSMETIC DENTISTRY

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PATIENT RECORD REQUEST FORM

I, ______________________________________ request that my records be transferred to Alvin C. Matthews, DDS, PC, at the above address.

Name of Patient Whose Record is Requested: ______________________________

DOB: ____________________________ Phone # ____________________________

Address: ___________________________ City/State/Zip: _______________________

Please provide a copy of the record as follows:

BWX taken within one year
FMX taken within 5 years
PANO taken within 5 years
Perio Chart

Date of Last Exam: ____________________
Date of Last Cleaning: __________________
Type of Cleaning: Child Prophy Adult Prophy Perio Maintenance Perio Scale

Recommended Recall Frequency: 3 month 4 month 6 month other_________

Date of Last Perio Scaling and Root Planing: ___________________

Treatment Recommended: None See Attached

Medical Concerns: ____

Signature: ________________________________ Date: ___________________

Relationship to Patient: _______________________

This authorization remains in effect for two weeks from the above date.