

**PATIENT RECORD REQUEST FORM**

STEVEN J. HORN, D.D.S.  
OAKSIDE DENTAL  
4032 10<sup>TH</sup> Street  
Menominee, MI 49858  
906-863-6381 Fax 906-863-4048

I, \_\_\_\_\_ request that my records be transferred to Steven J. Horn, D.D.S., 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 1 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 Prophyl Adult Prophyl Perio Maintenance Perio Scale

Recommended Recall Frequency (please circle the appropriate frequency)

3 month 4 month 6 month 12 month

Date of Last Perio Scaling and Root Planing: \_\_\_\_\_

Treatment Recommended: None See Attached

Medical Concerns: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

This authorization remains in effect for 2 weeks from the above date.