PATIENT RECORD REQUEST FORM

Henager, Black & Associates
8400 Gage Blvd
Kennewick, WA 99336

I, _____ request that my records be transferred to Henager, Black & Associates, 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 with in 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 (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 effect from the above date.