Request for Dental Records

From: **Dr. Theresa C. Hauck**
4310 Crystal Lake Road, Unit B
McHenry, IL 60050
(815) 344-5430

To: ____
(Previous Dentist)

____
(Street Address)

____
(City) (State) (Phone Number)

Name of Patient: ____

Patient DOB: ______________________ Phone: ____________________

Patient Address: ____

City/State/Zip: ____

Please provide a copy of the records indicated below:

- ○ Latest X-rays
- ○ Clinical Notes

Signature of Patient: _______________________________ Date: ___________