Dr. Paul F. DiMattia & Associates

Comprehensive Family Dentistry

REQUEST FOR RECORDS

I, hereby request that copies of dental **records** and **x-rays** for

_____, _____/_____/_____
Patient Name Date of Birth

be forwarded to the following dental practice:

Dr. Paul F. DiMattia & Associates
76 Bedford Street, Unit 8
Lexington, MA 02420

Or

staff@dimattia-dds.com

_____ _____/_____/_____
Patient or Guardian Signature Date

Address: _____

_____

_____

76 Bedford St., Unit 8 | Lexington, MA 02420 | (781) 862-0665 | fax (781) 861-6628
staff@dimattia-dds.com