Record Request Form

I _____, *hereby request that*
Parent or legal guardian name

*ALL dental records for*_____
Name of child or children

*From:*_____
Previous Dentist Name or Practice Name

*Address:*_____

*Phone Number:*_____

Be forwarded to: Please circle which address you would like them to be sent to

Kiddsmiles
1201 Northern Blvd
Suite 102
Manhasset, NY 11030
Tel: 516-365-5439
Fax: 516-365-5469

Kiddsmiles
1476 Deer Park Ave
Suite 2
North Babylon, NY 11703
Tel: 631-254-5437
Fax:631-940-5943

Kiddsmiles
315 Main Street
Suite 315-I
Holbrook, NY 11741
Tel: 631-254-5437

Kiddsmiles
2211 Merrick Road
Merrick, NY 11566
Tel: 516-365-5439

Thank you,

_____
Signature of parent or legal guardian

Please submit this form to XRAYS@KIDDSMILES.COM