

RECORDS REQUEST

If you would like us to contact your previous dentist and request any x-rays and records that would assist us in your treatment, please complete this form. If you do not have the address or phone number, please give us the dentist's name, city and state and we will attempt to find them for you. **Please return by mail, email or fax as soon as possible so can attempt to have your films available for your first visit.**

To: _____

Address: _____

City/State: _____

Telephone: _____

I authorize the release of dental information, periodontal charting and x-rays for the following family members. Please include full names and dates of birth.

Please send records to:
Thomas O. Marxen, DDS, MSD, PLLC
13515 NE 175th, Suite B
Woodinville, WA 98072
Phone: 425-483-2442
Fax: 425-485-0764
Email: marxendds@gmail.com

Patient or Guardian Signature

Date