PEDIATRIC DENTISTRY

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

Dentistry for Children
615 Broadway
Hastings-On-Hudson, NY 10706
Tel: (914) 478-8585
www.dfchastings.com

Dentistry for Children
107 South Broadway
Yonkers, New York 10701
Tel: (914) 378-7848
www.dfcyonkers.com

Dentistry for Children
22 North Divison Street
Peekskill, New York 10566
Tel: (914) 630-2600
www.dfcpeekskill.com

Thank you,

_____
Signature of parent or legal guardian