Mashni
DENTISTRY

REQUEST FOR X-RAYS

Date:_____

Patients Name: _____

Dear Doctor,

The patient listed above has requested that we contact you to arrange the transfer of their dental X-Rays. Our email address is: email@mashnidentistry.com

_____Please forward us all current radiographic materials.

Sincerely,

Mashni Dentistry

Patient Release:
I authorize the release of my dental X-Rays.

Signature:_____Date:_____

Date of Birth:_____

John W. Mashni, D.D.S., P.C. | James M. Mashni, D.D.S.
2121 Abbot Road | East Lansing, Michigan 48823 | 517.351.1733 | fax 517.351.5709 | www.mashnidentistry.com