Austin R. Smith DDS

5120 Corporate Center Ct. SE
Lacey, WA. 98503
Office: 360-352-2400 Fax: 360-352-6255
frontoffice@arsmithdds.com

Authorization to request Dental Records

I hereby request that a summary of dental care and/or duplicate x-rays be sent to:

Austin R. Smith DDS
5120 Corporate Center Ct. SE
Lacey, WA. 98501
frontoffice@arsmithdds.com

On the Following patient(s):

_____ DOB_____

_____ DOB_____

_____ DOB_____

_____ DOB_____

Please include BWX taken within the last 12 months and PAN/FMX taken within the last 3 years.

_____Date:_____
Patient / Parent / Legal Guardian Signature