CONSENT TO REQUEST DENTAL RECORDS

I, ____, do hereby consent and authorize
(Patient name)

___________________________________ located at _______________________ to send
(Previous Dental/Medical Office) (City, State)

copies of all dental records and radiograph to Drs. Ellen and Anne Bollmeier.

My date of birth is _________________________________and my social security number
(Patient date of birth)

is________________________________.
(Patient social security number)

Patient or guardian signature:__________________________________

Print:_____________________________________

Relationship to patient____

Date____________________________________

Please send all records to: Ellen Bollmeier, DMD, LLC
2010 W Hwy 50
O'Fallon, IL 62269

If you have any questions, please call our office at 618-622-8888.

Copies of the following records are specifically requested:

- ☐ Progress Notes
- ☐ Letters/Reports to/from Specialists
- ☐ Periodontal Charting
- ☐ Radiographs
- ☐ Medical History Forms