Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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AUTHORIZATION AND REQUEST FOR PREVIOUS DENTAL RECORDS AND RADIOGRAPHS

DENTIST/DENTAL GROUP: ____

FAX:______________________________TELEPHONE:___________________________

ADDRESS:____

CITY, STATE, ZIP____

PLEASE FORWARD PREVIOUS X-RAYS AND/OR RECORDS:

Dr. Angela Wandera & Associates
8785 Columbine Road
Eden Prairie, MN 55344

Email: clinic@drangelawandera.com

PATIENT NAME:____

DATE OF BIRTH:____

PARENT/GUARDIAN NAME:_______________________________

SIGNATURE:____

DATE:____