PATIENT RECORDS REQUEST FORM

Sullivan Dental
1440 S. Pottstown Pike
West Chester, PA 19380
Phone: 610-436-4088
Fax: 610-436-0679

Date: _____

Name of patient whose records are requested: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

List any dependents that will also need their records:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Reason for request:

- ☐ Change of insurance carrier
- ☐ Moving
- ☐ Other: _____

Name and address of where to forward records:

_____

_____

_____

_____

Signature of Patient (or guardian):_____