PHILLIPS | SCHMITT
DDS, PA

REQUEST FOR RECORDS

On this day I, _____, have requested that my
Printed or Typed Name

____ Dental Records ____ Medical Records *as noted below:*

- ☐ Dental Records and Radiographs
- ☐ Dental Radiographs
- ☐ Cone Beam CT Data and Studies
- ☐ Sleep Study and Diagnosis
- ☐ Medications and Dosage

are emailed/mailed to:

Phillips & Schmitt, DDS, PA
1111 Hendersonville Road
Asheville, NC 28803
828.254.1944
828.254.0104 (fax)
info@psdentistry.com

Patient Signature: _____ Date of Birth: _____

Parent/Guardian Signature: _____

Relationship to Patient: _____

Date: _____