



Patient Records/X-ray Request Form

Date _____

Previous DDS Information

Name _____

Phone Number _____

The patient listed below has recently transferred to our office for their dental care. The patient has requested the following information to be forwarded to our office.

_____ Bitewing Radiographs

_____ Panorex (if available)

_____ Other: _____

Please forward the above requested information to the following address:

**Grandville Family Dental Care, P.C.
3100 Wilson Ave, S.W.
Grandville, MI 49418**

If x-rays are in digital format, please send via e-mail to the following e-mail address:

gdfntdesk@sbcglobal.net

Patient Name (Print): _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Please feel free to contact our office if you have any questions.

3100 Wilson Ave., S.W., STE 3 • Grandville, MI 49418

Derek M. Draft, D.D.S.
Daniel G. Schultze, D.D.S.

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Phone: (616) 534-7138 Fax: (616) 534-7174

..... www.GrandvilleFamilyDental.com