Oil City Dental
1347 S. Beverly Street
Casper, WY 82609

Name of patient whose information you are requesting:

_____

Patient's Date of Birth: _____

The patient information you are requesting: **X-RAYS** **COMPLETE DENTAL RECORD**

Send To: _____

Email _____

Your Name: _____

ID Documentaion: **State**_____ **ID/Drivers License #** _____

Address: _____

City _____ **State** _____ **Zip** _____

Describe your authority to access this information :

_____

If you are a patient's personal representative (Parent/Guardian):

Relationship to patient: _____

I certify that the above information is correct.

Signature: _____ **Date** _____

***Copy of Identification required ***