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Date _____

Dentist Name: _____

Address: _____

Fax #: _____

Please send a copy of the most recent radiographs and records to our office on the following patient.

Thank you in advance for your timely response to this request.

Patients Name: _____ DOB _____

Address: _____

Patient/Guardian Signature: _____

Date: _____

Sincerely,

Dr. Brian T. Seese/Staff

***Our office prefers digital radiographs sent to our email address: *smilesbyseese@att.net* ***