MICHAEL S. MEAD JR. DDS
STATE-OF-THE-ART DENTISTRY PRACTICED WITH CARE.

Request to Send Dental Records & Radiographs to Dr. Mead

To: Previous Dentist: _____

Address: _____

City, State, Zip: _____

Phone Number: (_____)-_____-_____

Email: _____

I, _____, authorize you to release my records to Michael S, Mead, Jr. DDS. Please forward any previous dental records and/or radiographs as soon as possible to:

Michael S. Mead, Jr. DDS Inc.
12981 Cleveland Ave. NW
Uniontown, OH 44685
Phone: (330) 699-2523
contact@MichaelMeadDDS.com

Other Family Members to Transfer:_____

_____

_____

Sincerely,

Signature: _____ Date: _____

Patient Name: _____ Date of Birth:_____

Phone Number: (_____)-_____-_____