1215 Vine Street
Gainesville, GA 30501
770-532-4555
770-536-8053 FAX

I, _____ request that my dental records be sent

to BGW Dental Group from:

Office name: _____

Office phone number: _____

Signed:_____

Date of Birth: _____

Other Family Members:

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Requested from:

BGW Dental Group

clinical@bgwdentalgroup.com