Records Request Form

_____ _____

Patient Name **Date of request**

Please provide all records available that you can secure from your previous dentist or medical practitioner & send to the following address or email. Sign and send this form to your previous provider.

____ X rays and date taken

____ Medical releases from current illness

____ Ct Scans and date taken

____ MRI and date taken

____ Blood work and date taken

____ Photographs and date taken

____ Previous treatment plans and all billing, invoices, etc…

____ A summary in your own words of your concerns, past solutions, present problems and potential outcomes desired.

I, _____ request copies of all my dental/medical records including all images, clinical and financial notes including any communications from specialists on my behalf sent to the below practitioner within 10 days of receipt of this request.

_____ _____

Patient Requesting Signature **Date**

Please email these records to: NiloDentist@gmail.com
(if sending by email, please use secure HIPPA compliant email service)
Physical address to mail:
Smilecreator of Naples LLC c/o: Custodian of records
987 High Point Drive, Suite 102
Naples, Fl. 34103
Office tel: (239) 564-3100

Or bring them in to your appointment. Bear in mind, this last option will delay your visit once at the office.