DATE: _____

TO: DOCTOR: _____

ADDRESS: _____

PHONE: _____ **FAX.:** _____

I hereby authorize and request you to please send bitewing x-rays (if taken within 1 year) and Full-Mouth Series and Panorex (if taken within 5 years) TO:

ABERDEEN DENTAL ASSOCIATES
11800 Aberdeen St. NE, Ste. 110
Blaine, MN 55449
Phone (763) 786-4280 FAX (763) 754-6226

PATIENT NAME (Please Print) _____

SIGNED (Patient/Guardian) _____

RELATIONSHIP _____