

Altoona

Pediatric

Dental

Record Release Request

Please e-mail my child's records and radiographs to:
staff@altoonapediatricdental.com OR mail to:

Altoona Pediatric Dental
480 Center Place SW
Suite A
Altoona, IA 50009
515-967-9790

Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent / Legal Guardian: _____

Signature of Parent / Legal Guardian: _____

Radiograph History / Date

- Bitewings _____
- Panoramic _____
- Full Mouth _____
- Periapical _____

Professional Care / Date

- Prophylaxis _____
- Fluoride _____
- Sealants _____
- Restorations _____

