WEST HAVEN
DENTAL CARE LLC
Anthony D. Bellucci, D.M.D.

REQUEST FOR DENTAL RECORDS

Date: ________________

Dear Dr. ____________________________

I hereby request the release of all dental x-rays and records for:

(Patient's name & address) ____

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Please forward any recent x-rays and all other pertinent information to:

West Haven Dental Care L.L.C.
Anthony D. Bellucci, D.M.D.
640 Savin Ave
West Haven, CT 06516

Thank you for your cooperation.

Signature: ____

If you are signing as the patient's representative:

Print your name: ____________________________________

Describe your authority: Parent_____ Legal Guardian _____ Other ________________