Print Form

Patient Record Request Form

Joy M. Miller, D.D.S.
4268 N. Oak Trafficway
Kansas City, MO 64116
816-452-5800

I, _____request that my records be transferred to Joy M. Miller, at the above address.

Name of Patient Whose Record is requested:_____

DOB:_____ Phone#:_____

Address:_____

City, State, Zip_____

Please provide a copy of the record as follows:

*BWX (taken within one year)

*FMX/Pano (taken within 5 years)

*Digital x-rays should be emailed to *info2@joymillerdds.com*. (Must be in *.jpeg format)

Perio Chart

Date of Last Exam:_____

Date of Last Cleaning:_____

Type of cleaning: Child Prophy ○ Adult Prophy ○ Perio Maintenance ○ SRP ○

Date of Last Perio Scaling and Root Planing:_____

Signature:_____ Date:_____

Relationship to Patient:_____