

**Shamblott Family Dentistry**  
**Scott E. Shamblott, DDS, FAGD, PA**  
**33-10<sup>th</sup> Ave South, Suite 250**  
**Hopkins, MN 55343**  
**952-935-5599**  
**Fax 952-935-7842**  
**www.shamblottfamilydentistry.com**

**REQUEST FOR PATIENT RECORDS**

Date \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_ (Street)

\_\_\_\_\_ (City, State, Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please send a **complete** copy of my dental records (**X-RAYS, CHART NOTES AND TREATMENT PLANS**) to Dr. Scott Shamblott at

**Shamblott Family Dentistry**  
**33 Tenth Avenue South, Suite 250**  
**Hopkins, MN 55343**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ (Street)

\_\_\_\_\_ (City, State, Zip)

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_