SHOOP
DENTISTRY

Radiograph and Chart Notes Request Form

Date:_____

Our patient has requested that his/her most current or requested radiographs are forwarded to our office.

Name of Dentist's office forwarding radiographs:_____

Patient Name:_____

Patient Signature:_____

Date of Birth:_____

Please forward most recent or requested radiographs to:

Office@ShoopDentistry.com
Dr. Daniel R. Shoop DDS
700 S. 320th St. Suite E
Federal Way, WA. 98003
253-946-3575

If you have any questions or concerns, please call our office at 253-946-3575

Thank you,

Jenna & Dana
Office Coordinators