DENTAL ASSOCIATES OF WALPOLE

1428 Main Street, Suite 1
Walpole, MA 02081
Tel: 508.668.8008
Fax: 508.668.8808

Request of Dental Radiographs and Records

Date of request: _____

Previous Dentist Name: _____

Address: _____

Phone Number:_____ Date: _____

Please transfer dental records/x-rays for:

1. _____ DOB: _____

2. _____ DOB: _____

3. _____ DOB: _____

4. _____ DOB: _____

5. _____ DOB: _____

Please email digital records to:
Records@DentalAssociatesOfWalpole.com

Please send printed records to:
Dental Associates of Walpole
1428 Main Street, Suite 1
Walpole, Massachusetts 02081

Signature (patient, parent or legal guardian): _____

Print name (patient, parent or legal guardian):_____