Dr. Michael Eickman

310 Red Lake Blvd
P.O. Box 655
Thief River Falls, MN 56701
(218) 681-2545 Fax (218) 681-2560

Date: _____

To: _____

_____

_____

I hereby request that copies of my dental records be transferred to Thief River Falls Family Dentistry at the above address.

Please send records for: _____,

_____, _____,

_____, _____,

☐ *Complete Records*

☐ *Recent X-Rays* ☐ *Bitewings* ☐ *Panelipse* ☐ *FMX*

☐ *Other:* _____

Thank you for your help and cooperation.

Signed: _____

Date: _____