



IMPRESSIONS DENTAL

5970 S. Cooper Rd., Ste #1 Chandler, AZ 85297 480-814-8888 office / 480-814-1553 fax

Date _____

Dentist Name _____

Address _____

**Please send a copy of the most recent radiographs and records to our office.
Thank you in advance for your timely response to this letter.**

Patient Name _____ Date of birth _____

Address _____

Patient/ Guardian Signature _____ Date _____

Sincerely,

Impressions Dental, PC
Office Manager