Aaron T. Roan, D.M.D.
& Associates
Family & Cosmetic Dentistry
2590 PARK CENTER BLVD., STE 100 STATE COLLEGE, PA 16801
#814-234-6826

Fax #: 814-234-2497

Please mail this to your former Dentist

Date:_____

Dear Doctor_____:

*****TRANSFERRING DENTIST ADDRESS/PHONE NUMBER/ EMAIL ADDRESS:**

_____

_____

_____

I am requesting that you please send my/my family's current records/ radiographs to

Aaron T. Roan & Associates

Last FMX : _____ **Last Periapical x-rays: _____**

Last Bitewing x-rays: _____ **Last prophy and exam: _____**

PATIENT: _____Date of Birth: _____

PATIENT: _____Date of Birth: _____

PATIENT: _____Date of Birth: _____

PATIENT: _____Date of Birth: _____

Sincerely_____
(Patient's signature) **(Date)**