FEDERAL WAY
General & Laser Dentistry

Date: _____

I _____ am requesting a copy of dental treatment records for myself, and/or family members listed below. Please send copies of most recent full mouth series, panoramic image, bitewings, periapical images, and periodontal charting be sent to:

Federal Way Laser Dentistry
C/O Jonathon Einowski DDS
720 South 320th Street, Suite I
Federal Way, WA 98003

If digital, please email records to our encrypted email address: smile@einowsikidds.com
Phone# (253) 839-5953 Fax# (253) 839-9335

Patients records to be sent:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient/Guardian's Address for verification: _____
Patient or Guardians best number to be reached if needed: _____

Name of office/doctor sending records: _____ Phone# _____

Additional Notes:
(Optional)_____
_____
_____
_____

Thank you for your assistance,

_____
Name Printed

_____
Signature of Patient/Guardian