Amy F. Temple
Family Dentistry D.D.S., P.A.

I, _____ request that copies of
(Patient or guardian)

All Radiographs for:

Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Be **sent from**:

DR._____

Address_____

State, Zip_____

Phone _____

Fax _____

And be **forwarded to**:

Amy F. Temple, DDS
840 Salisbury St.
Kernersville N.C. 27284
(336) 993-5599
(336) 993-0877 FAX
E-mail: records@amyftempledds.com
(Digital x-rays accepted)

Please forward these records as soon as possible. Thank you.

_____ _____
Patient or Guardian Signature Date