

Dr. Ryan Sigmon

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\*\*complete ONLY if you would like x-rays sent to Compass Dental from your last dental office\*\*

Patient's Signature	Date
Please e mail the records to the e mail address list	ed above.
Doctor's Phone:	
Doctor's Address:	_
Doctor:	
Dostor	
I am requesting that my records be sent from:	
Additional Family Members to include:	
Date of Birth:	
Patient's Name:	
Dationt's Namo:	