

Joseph P. Steiner, D.D.S.  
Kevin R. Ventrucchi, D.D.S.  
7373 147<sup>th</sup> St. W. Suite # 116  
Apple Valley, MN 55124

## X-RAY REQUEST FORM

Please complete this form and send it to your previous Dentist or sign  
release for us to release x-rays to another dental office or to take with you

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_  
Home Phone: \_\_\_\_\_ work# \_\_\_\_\_

Previous Doctor / Provider

Dr. \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

### SERVICES DESIRED

- current full mouth x-rays available  
 current panoramic film  
 current bitewings available  
 current periapical (tooth # \_\_\_\_\_)

Patient  
Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please return response to

Joseph P. Steiner D.D.S.  
Kevin R. Ventrucchi, D.D. S.  
7373 147<sup>th</sup> St W Ste.# 116  
Apple Valley, MN 55124-7532  
952-432-8110 Fax 952-432-4457  
Attn: Patient Records