Merrimack Dental Associates

Records Request

I, _____**DOB:** _____ am requesting that a copy of my current radiographs be forwarded to Merrimack Dental Associates.

Previous Dental Office Information

Office:_____ Phone Number:_____

Email:_____

Please email to: office@merrimackdental.com

Patient/Guardian Signature: _____ Date: _____

170 South River Rd Building II Suite 4 Bedford, NH 03110
Phone: 603-424-6131
Fax: 603-424-3620