Xray / Records Release

*Please complete and mail or fax to your previous dentist.

Date: ___________________

Please send all current records including bitewing xrays taken within the last 24 months, full series or panoramic xrays taken within the last 5 years, and any other pertinent dental records to:

Excellence In Dentistry
Drs. Hill, Sergeant & Batchelor
1001 North Sherman Avenue
Madison WI 53704

Phone (608) 240-1001
Fax (608) 240-1551
Email: inquiry@ExcellenceInDentistry.com

I have an appointment scheduled on : ______ / ______ / ______

- Please cancel any future appointments YES / NO
- Please include xrays for my children YES / NO

Name: ____________________________________ Date of Birth: ___/___/___

Address: ____________________________________

City State ZIP: _______________________________

Signed: ______________________________