

# X-Ray Request Form

Valley View Dental Care

Dr. Eric Barrientos

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info@valleyviewdentalcare.com

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I am requesting that my dental records be sent to Valley View Dental Care from:

Practice Name: \_\_\_\_\_

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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