Peter A. Timian, DMD

636 Lincoln Highway
Fairless Hills, PA 19030
215.295.8783
TimianDMD@comcast.net
FAX: 215.295.2767

X-RAY TRANSFER REQUEST

Date: _____

To the office of:_____

Patient Name:_____

Date of Birth:_____

Phone Number:[____]_____

Email: _____@_____

I authorize the release and transfer of dental x-rays to the office of
Dr. Peter A. Timian, DMD.
Please MAIL all films [both classic film and printed digital films].

Peter A. Timian, DMD
636 Lincoln Highway, Suite 11
Fairless Hills, PA 19030

Your timely processing is greatly appreciated as I have an appointment scheduled on _____.

_____ _____
Signature: Date: