REQUEST FOR CLINICAL DENTAL INFORMATION

Please Print Clearly or Type

Dear Doctor,

Please review the following request for dental information listed below, as they may be critical to an identification of:

_____

Address _____

_____

DOB ____ ____ _____

who is thought to be a patient in your office. This individual is missing and identification by visual or fingerprints may not be possible. Therefore, to assist in the identification, a dental report is being prepared for entry into the **FBI NCIC, NDIR and DOJ / NamUs** databases. For this report we require your cooperation in obtaining **original dental records and radiographs. Duplicates are not acceptable.** Please release all available records and radiographs to the officer or send the records to the address on the back of this form. All dental records will be promptly returned unless required for evidence. Please consider this request as **CONFIDENTIAL**. Thank-you.

_____
Dentists Name

_____
Office Address

_____
City State Zipcode

_____
Office Phone

_____
Home Phone

_____
Beeper/Cell Phone

_____
Email Address

Doctor, please complete the information above and staple your business card in this spot. Please include a beeper and or pager number if available. We want to insure that the records entered for your patient are accurate and of sufficient quality to be capable of rendering an accurate comparison for identification purposes.

Dental Records Request

Please indicate below the records that you are forwarding. Please label all radiographs with date taken and label left and right. Please sign and date in the area below. If you have digital radiographs, please send as a jpg file to: _____

- ☐ All dental / periodontal charts
- ☐ All bitewing radiographs
- ☐ All periapical radiographs
- ☐ All panoramic radiographs
- ☐ Other radiographs
- ☐ Dental models
- ☐ Clinical progress notes
- ☐ Specialist referrals, including name, address and phone number
- ☐ Hospitals where radiographs of the head and neck may have been taken.
- ☐ Patient's insurance company including address, phone number and insured person if not the patient.
- ☐ _____

_____ _____

Signature Date