NORTHWESTERN UNIVERSITY
DENTAL SCHOOL
Patient Records Request

NOTE: This form must be completely filled out for proper processing

Date_____ Records_____ X-rays_____

Name (in full)_____

Male ____ Female___

Clinic Number (if available)_____

Approximate date of last visit_____

Social Security number_____ Birth Date_____
Home address_____
No. & Street

_____
City, State, Zip Code

Telephone_____

Send to Address (if different than home address)

_____
Attn to: No. & Street

_____
City, State, Zip Code

_____ _____
Patient Signature (or parent/guardian signature) Date

Mail/fax to: Dental Records, Office of the Provost, 633 Clark St., Evanston, IL 60208-1119; (847) 467-1630