

Curtis A. Brookover, D.D.S.  
3491 Trinity Drive, Suite A  
Los Alamos, NM 87544  
Phone (505)662-4503  
Fax (505)662-4117  
Los Alamos Office

Curtis A. Brookover, D.D.S.  
409 St. Michaels Drive, STE A  
Santa Fe, NM 87505  
Phone (505)982-6426  
Fax (505)930-5854  
Santa Fe Office



**Integrative Dentistry of New Mexico**  
**Request for Records**

I am requesting a copy of all dental records including X-rays, for myself and /or a member of my family to be mailed to the above checked office. (Please check Los Alamos or Santa Fe at the top of the page)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please send digital x-rays to: **bo@jdofnm.com**

**Previous Dentist(s) Information:**

Office Name: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**(Additional Dentist if you have been to more than one dentist in the last two years)**

Office Name: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I \_\_\_\_\_, acknowledge that I have the authorization to make such a request for myself or any of the above named patients to whom I am a legal guardian.

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