



# Stadsklev

DENTAL

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

Dr. \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

Dear Doctor,  
Thank you for your past dental care. I am requesting my current  
x-rays and perio charting be sent to:

Stadsklev Dental  
220 22<sup>nd</sup> Ave E, Ste#105,  
Alexandria, MN 56308  
Fax-888-763-0267  
Email-[info@stadsklevdental.com](mailto:info@stadsklevdental.com)

I appreciate your prompt reply,

Sincerely,

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