Please forward the most recent Panorex, FMX or Bitewings for the patient listed below.

Patient: _____

Date of Birth: _____

Email is preferred: **bsmiles@ptd.net**

If email capabilities are not available you may mail x-rays to:

**Bethlehem Smiles**

**2597 Schoenersville Rd, Ste 301A**

**Bethlehem, PA 18017**

Patient /Guardian Signature: _____

Date: _____