State of Maryland
Office of the Chief Medical Examiner
Forensic Medicine Center
111 Penn Street, Baltimore, MD 21201-1020
(410) 333-3250 Fax (410) 333-3063

DENTAL RECORDS REQUEST

Dear Doctor:

Please review your following items, listed on this reverse, as they are essential in the possible identification of

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Address ______________________________

____

SSN: ______________ DOB: __________

OCME Case #: ______________________

who is thought to be patient in your office. We believe this individual may be involved in an incident in which visual and fingerprint identification are uncertain. Therefore, in order to identify this individual we require your cooperation in obtaining **original dental records and radiographs. Duplicates are not acceptable.** Please forward all available records and radiographs to the officer or courier present.

Thank you,

David R. Fowler, M.D.
Chief Medical Examiner

____
Dentist's Name

____
Office Address

____
City State Zip Code

(____)__________________________
Office Phone

(____)__________________________
Home Phone

(____)__________________________
Beeper / Cellular Phone Number

Doctor, please review the above information and make corrections if necessary. Please staple your business card in this spot. It may be necessary to contact you for details in order to facilitate the identification.

(OVER)

DENTAL RECORDS PROVIDED TO:

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Please indicate below, records you are forwarding. Please indicate right and left on mounted radiographs. Please sign and indicate date records sent or given to courier.

- ☐ All dental / periodontal charts
- ☐ All bitewing radiographs
- ☐ All periapical radiographs
- ☐ All panoramic radiographs
- ☐ Other radiographs (Cephs. etc.)
- ☐ Dental models
- ☐ Clinical progress notes
- ☐ Specialist referrals, including names, addresses and phone numbers
- ☐ Hospitals where radiographs of head and neck have been made
- ☐ Patient's insurance company, including address, phone number
- ☐ ______________________

______________________ Signature

______________ Date