

Dental Records Release Form

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info@gloucesterfamilydentistry.com

Patients Name: .

Date of Birth: .

Best Contact Number: .

Other Family Members to Transfer: .

Previous Dentist or Practice Name: .

Email: .

Phone Number: .

Fax Number: .

\*\* PLEASE FORWARD ANY OF THE FOLLOWING INFORMATION THAT YOUR OFFICE HAS REGARDING THE ABOVE LISTED PATIENT(S) \*\*

Bitewings – Date taken: .

PAs – Date Taken: .

PAN – Date Taken: .

Complete Oral Exam: .

Last Recall Exam: .

Last Polish Fluoride: .

\*\* PLEASE SEND MOST RECENT COPY OF PERIO CHART FOR ABOVE PATIENT(S). THANK YOU.\*\*

I hereby give you permission to release any and all of my dental records to Gloucester Family Dentistry.

Patient’s Signature: . Date: .