Transfer of Records

Date: _____

Dentist: _____

Phone: _____

I Authorize release of my most recent radiographs to:

Orleanswood Dental
7788 Jeanne D'Arc Blvd. N.
Orleans, On. K1C 2R5
Email: admin@orleanswooddental.ca
Tel: 613-824-7288

Date of Complete Exam _____

Panoramic X-ray _____

Bw Bitewing/Pa _____

Date of last Rc Exam _____

Date of last scaling _____

Date of polishing _____

Name of Patient(s)	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient:

_____