

DUNDAS

HERITAGE
DENTISTRY

LEGACY | INNOVATION | COMFORT

6 Sydenham Street | Dundas ON L9H 2T4 | 905-628-6541 | dundas@drchalice dentist.ca
dundasheritagedentistry.com

Release of Records

Previous Office Name (to send release to): _____

Patient Name (please print): _____ **Date Of Birth:** _____

I authorize the release of my information and radiographs to Dundas Heritage Dentistry.

Date Of Most Recent New/Complete Patient Exam _____

Date Of Most Recent Recall Exam _____

Date Of Most Recent Panorex Radiograph _____

Date Of Most Recent Bitewing Radiographs _____

Date of Most Recent Periapical Radiographs _____

Recent Dental Treatment (in the last 12 months)

Patient Signature: _____ **Today's Date:** _____

OFFICE USE: Date sent: _____

Date records received: _____

