Westmeadow Dental

X-RAY RELEASE CONSENT FORM

DATE**:** _____

ATTN: _____

TELEPHONE: _____ FAX: _____

I, _____ give authorization for

Dr. _____ (previous dentist) to release my dental information and x-rays to the office of;

Westmeadow Dental
420 Westmeadow Drive
Kitchener ON N2N 3J4
Tel. 519.745.3621 Fax. 519.745.3441
Email: info@westmeadowdental.com

Please include the most current x-rays, in addition to any full mouth series, and panoramic radiograph taken within the last five years.

PLEASE FILL OUT DATE BELOW:

LAST RECALL EXAM: _____

LAST COMPLETE EXAM: _____

LAST BITEWINGS: _____

LAST PANOREX: _____

Patient Signature: _____