EARLSBRIDGE DENTAL

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Brampton, ON, L7A 3P1

(905) 846-6661

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Dental X-Ray Release Form

Patient Information (CONFIDENTIAL)

Patient Name

Date of Birth

Additional Family Members to Transfer:

Last COE:

Last Recall:

Last BW:

Last Pan:

Last FMX:

Previous Dentist/Dental Practice Information

Dentist/Dental Practice Name:

Address:

Phone:

Fax:

Authorization

I hereby give permission and request to release any and all of my dental/treatment x-rays:

First & Last Name

Email Address

Signature

X

If X-rays are digital please send via email to: info@earlsbridgedental.com

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