

NORTH VAN DENTAL

RECORDS TRANSFER

Date: _____

Dr: _____ Phone #: _____ Fax #: _____

I hereby request and authorize the transfer of my dental records to the dental office indicated below.

Please include the following (if available):

- All radiographs (full mouth series)
- Copies of periodontal charting; particularly pockets, furcas and recessions
- Letters and/or reports from specialists
- Study models or duplicates

Please send all available records to:

North Van Dental
2601 Westview Drive
North Vancouver, BC V7N 3X4
(604) 669-1195
info@northvandental.ca

Thank you very much,

Patient (full name): _____

Date of birth: _____ Phone: _____

Signature of patient or parent (if a minor)