X-Ray Release Form

Bright Dental Centre
Family, Cosmetic and Implant Dentistry
305 Castor St, Russell, On K4R 1G6
Tel: 613-445-0885
Fax: 613-445-0886
Email: info@brightdentalcentre.com

Date: _____

Former Dentist:_____

Phone: _____Fax: _____

Dear Dr. _____

_____has recently become a patient of our practice. We would like to request copies of their photographs be forwarded to us. Furthermore, if you would kindly provide us with the following information in order to help us in servicing this patient's dental needs.

Date of new patient exam (01103): _____

Date of last recall exam (01202-11101-11111): _____

Date of last bitewing radiographs: _____

Date of last panoramic radiograph: _____

Date of fillings done in the past 24 months: _____

Crown/ Root canal treatment done in the past 24 months: _____

Sincerely,

Bright Dental Centre

I hereby authorize the release of my dental records and radiographs to Bright Dental Centre.

Patient/Parent's signature_____