URBAN DENTAL
CENTRE DENTAIRE

TRANSFER OF RECORDS

To: Dr _____

Phone: _____ Fax: _____

I, _____ authorize you to release the most recent dental radiographs and dental records to:

Urban Dental Centre
Dr. Katia Doumit
PLEASE FORWARD INFO TO
Fax: **613-232-8100**
or email: request@urbandentalcentre.com

Please include the following:

Date of last **complete exam**: _____

Date of last **recall exam**: _____

Date of last **panoramic x-ray**: _____

Date of last **bitewing x-rays**: _____

Date of last **scaling/polishing**: _____

Patient/Parent/Guardian Signature: _____

Witness Signature: _____

Date: _____