Request for Dental Records

Date: _____

Healthy Smiles is requesting records from (office name): _____

Patient Name: _____ Date of Birth: _____

Please provide copies of the following records:

____ PA & Bitewing radiographs within the last 12 months

____ Panorex radiographs within the last 5 years

____ Other: _____

____ Include records for family members

Patient Consent

I, (name)_____, authorize the release of the records indicated above.

Other Family Members:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Patient Name: _____

Signature: _____ Date: _____

Please forward records to: info@dentalhealthysmiles.com

237 - 4919 59 St, Red Deer AB T4N 6C9
Phone: 403-986-8000 | Fax: 403-986-8020 | Email: info@dentalhealthysmiles.com
dentalhealthysmiles.com