

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 surveys)

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:

Edgemont Dental Care
Dr. Craig Siemens, Inc.
Suite 2 - 3046 Edgemont Blvd.
North Vancouver, BC V7R 2N4
604.985.9535

Thank you very much,

Patient (full name): _____ Date of birth: _____

Phone: _____

Signature of patient or parent if minor