CONSENT FORM

FOR THE RELEASE OF DIAGNOSTIC RADIOGRAPHS AND/OR RECORDS FROM A PREVIOUS DENTAL OFFICE

(One Form Per Adult)

Dentist: ______________________ Date: ______________

Attention: ______________________

PATIENT INFORMATION

Permission is hereby granted to release information for the dental / medical history of:

Print Patient Name: ______________________

Signature of Patient or Parent/Legal Guardian if Patient is under 18: : ______________________

Print Name of Parent/Legal Guardian: (if Applicable) ______________________

Relationship of Guardian to Patient: (if Applicable) ______________________

Radiographs and Records are to be sent to:

Dr. Samantha Wong
Winona Dental
1262 Highway 8
Stoney Creek, ON
L8E 5K3
Phone: 289 656 0599
Fax: 888 875 3756
E-mail: sabrina@winonadental.com

Specific Materials Requested:

Date of:

- Last Complete Oral Exam (01103) performed
- Last Recall (01202) & Specific exam (01204)
- Last Cleaning & Units
- Records of Treatment
- Pan if within 5 years
- Last Bitewings (02144, 02142) if within 2 years
- Full Mouth Series if within 5 years

Print Witness Name: ______________________

Signature of Witness: ______________________