KINCARDINE DENTISTRY

Radiograph & Information Release Form

Office of: _____

Patient(s): _____

☐ Self ☐ Family

Phone number: _____

Fax number: _____

Please release the most recent information regarding the above patient(s)

New patient/COA: _____

PAN: _____

(Copy is required regardless of date)

BW: _____

Recall: _____

Scale: _____

Polish: _____

Fluoride: _____

Perio charting: _____

Outstanding tx: _____

Pertinent info: _____

Please forward records to the office of:

Kincardine Dentistry
6 Millennium Way
Kincardine, Ontario
N2Z 0B5
519-395-5100 (p)
519-395-5109 (f)
info@kincardinedentistry.com * Please email x-rays in JPEG format *

I authorize the release of the above-mentioned information.

Signature: _____

Dated: _____

Thank-you in advance for your help!