FAMILYDENTAL

GUILDFORD **FAMILY** DENTAL

RECORDS TRANSFER

Clear Form | Print

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 series)
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:

Guildford Family Dental
1250-10355 152nd St,
Surrey, B.C. V3R 7C1

(604) 584-9988
info@guildfordfamilydental.com

Thank you very much,

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

_____
Signature of patient or parent if minor