

# Niagara Dental Centre

905-356-0222

**Fax:** 905-356-9674

appointments@niagaradentalcentre.com

Previous Dental Office:

\_\_\_\_\_

## Record Release Form

Date:

I \_\_\_\_\_, request that duplicate x-rays and the following dental records be forwarded to Niagara Dental Centre for client/s.

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\_\_\_\_\_

\_\_\_\_\_

- Date of last Scaling: \_\_\_\_\_ Units used: \_\_\_\_\_
- Date of last Recall \_\_\_\_\_
- Date of last COE \_\_\_\_\_
- Date of last PAN or FMS \_\_\_\_\_
- Date of last set of BW's \_\_\_\_\_
- Date of last visit \_\_\_\_\_
- Notes/ additional information \_\_\_\_\_

I understand that this document will be sufficient to serve as a legal release as required by the RCDS since November 1995.

Patient Signature:

Address:

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