DENTISTRY

Dr. Maureen Fenn BSc,DDS

RADIOGRAPH & RECORDS RELEASE FORM

Date: _____

Dear Dr._____

Phone#_____ Fax#_____

Please release the following and mail, or email, to our office:

X_Any full mouth series
X_Bite Wing radiographs taken within the last 2 years
X_Any available panographic radiographs

Please provide the following information:

X_Date of last Complete Exam 01103, 01102, 01101_____
X_Date of last full mouth series_____
X_Date of last Recall Exam (01202)_____
X_Last scaling/polishing _____

For:_____

Patient Signature_____

Date_____

drfenn@sympatico.ca

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