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_______________________________

1411 Danforth Avenue
Toronto, ON M4J 1N2
416-469-2454
drfennreception@gmail.com