
I, _____ (name of patient, parent or guardian), hereby request and authorize
_____ (name of previous dentist/dental clinic) to provide 2000 Yonge Dental
with copies of my/my family's dental records, radiographs and any other information as outlined below.

Phone number of previous dentist/dental clinic - -

Email of previous dentist/dental clinic _____

Signature of patient, parent or guardian _____ Date DAY MO YEAR

TO BE COMPLETED BY PREVIOUS DENTIST/DENTAL CLINIC

In order for 2000 Yonge Dental to continue providing the above named patient(s) with the same level of care he/she is accustomed to, please provide the following information:

- A summary of all information pertinent to the above noted patient(s) continued treatment.
- Copies or original films from most recent full mouth series, panoramic films and films taken within the last 24 months.
- Date of last new patient exam (O1103)

DAY MO YEAR

- Date of last full mouth series and/or PAN (O2102 or O2601)

DAY MO YEAR

- Date of last BW (O2142 or O2144)

DAY MO YEAR

- Date of last recall appointment (O1202)

DAY MO YEAR

Your cooperation with this request is greatly appreciated. Thank you. If you have any questions, please contact us at info@2000yongedental.com or (416) 807-2000.
