ATLANTIS DENTAL

FAMILY & COSMETIC DENTISTRY

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:

Atlantis Dental Centre
1278 Pacific Boulevard
Vancouver, BC V6Z 2V1

(604) 899-0775
info@atlantisdental.ca

Thank you very much,

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

_____
Signature of patient or parent if minor