Danforth Neighbourhood Dental Centre
643 Danforth Ave. Toronto, Ontario
www.dndc.ca

Phone: (416) 466-8003
Fax: (416) 466-8187
Email: dentistry@dndc.ca

REQUEST FOR TRANSFER OF DENTAL RECORDS & RADIOGRAPHS

Date: _____

Dear Dr. _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Patient Name (1) _____

(2) _____

The patient kindly requests that you forward a copy of dental treatment records, radiographs and any other information which may be pertinent to their treatment. Bitewings taken within the past 2 yrs, panorex or full mouth series.

- Please include the date of the last Complete Oral Exam _____
- Date of last bitewings _____
- Date of last pan or full mouth series _____

We thank you in advance.

Regards,

Dr. A. Syriopoulos
DNDC Clinical Director

Patient's signed request: _____