#130, 630 Redstone Dr. NE
Calgary, AB T3N 1B6
Phone: (587) 356-0555

Request for Dental Records

Date: _____

Dental office requesting from: _____

Phone Number: _____

Fax Number: _____

Please provide copies of the following records:

____ PA & Bitewing radiographs within the last year

____ Panorex radiographs within the last 5 years

____ Other: _____

____ Include records for myself only

____ Include records for family members

Patient Consent

I, _____, authorize the release of the above mentioned records to Redstone Smiles Dental.

Patients Name (Please Print): _____ DOB : ____/____/____

Other Family Members:

Name: _____ DOB : ____/____/____

Name: _____ DOB : ____/____/____

Name: _____ DOB : ____/____/____

Name: _____ DOB : ____/____/____

Name: _____ DOB : ____/____/____

Signature: _____

Please forward records to:

Redstone Smiles Dental
info@redstonesmilesdental.com