Airdrie Dental Studio

Request for Dental Records

Dental Office requesting from:_____

Phone number: _____

Please provide copies of the following records:

____ Bitewing radiographs within the last year

____ Panorex radiograph 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 the Airdrie Dental Studio.

Date: _____

Patient Name (please print): _____

Other Family Members: _____

Signature: _____

Please forward records to:

Airdrie Dental Studio
#1 704 Main St.
Airdrie, AB T4B 3M1
info@airdriedental.ca

Phone: (403) 912-9688
Fax: (403) 948-5753