CENTRE DENTAIRE FAMILIAL
TRAILSEDGE
FAMILY DENTAL

Transfer of Radiographs/Records

PATIENT NAME(S): _____

_____

TRANSFER TO: Trailsedge Family Dental ; (613) 800-0022

Name of dentist / dental clinic: _____

Address / City & Phone Number: _____

On behalf of the above patient(s), we would like to thank you for your care. This (these) patient(s) is (are) transferring to our office, and we would appreciate the following information:

_____

Office Use Only:

DATE OF LAST COMPLETE EXAM (01103): _____

DATE OF LAST RECALL EXAM (01202): _____

DATE OF LAST DENTAL CLEANING (01103): _____

DATE OF LAST PANOREX TAKEN: _____

DATE OF LAST BITEWINGS TAKEN: _____

DATE OF LAST PA'S (and tooth numbers): _____

Please forward any bitewing x-rays taken within (1) year and PAN taken within the last (3) years.

Any other relevant information, (specialist reports, extensive treatment completed, etc.) would be greatly appreciated.

_____

PATIENT SIGNATURE: _____ DATE SIGNED: _____

6160 Renaud road Ottawa, ON K1W OL1
trailsedgefamilydental@gmail.com
1(613)800-0022