ALL Care DENTAL

Request for dental records

TO GET YOUR X-RAYS AND NOTES SENT OVER

5105 Hurontario Street, Unit 6, Mississauga ON L4Z 0C9 · 647.479.3151 · info@allcaredental.ca

Your previous dentist keeps your X-rays and notes and needs your signature before releasing them. Fill this in, sign it, and hand it in at our office — or give it to your previous dental office yourself.

OFFICE USE · REQUESTED	RECEIVED

ABOUT YOU

LAST NAME	GIVEN NAMES	DATE OF BIRTH	TODAY'S DATE

ANY EARLIER NAME YOUR RECORDS MAY BE UNDER	CELL PHONE	EMAIL

APT.	STREET ADDRESS	CITY	POSTAL CODE

YOUR PREVIOUS DENTAL OFFICE

DENTIST'S NAME	NAME OF THE PRACTICE	PHONE	FAX, IF YOU KNOW IT

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

EMAIL OR WEBSITE, IF YOU KNOW IT	ROUGHLY WHEN WERE YOU LAST SEEN THERE?

WHAT WE ARE ASKING FOR

1. Please tick what should be sent:

- ☐ All records you hold
- ☐ The most recent X-rays
- ☐ Panoramic or 3D images
- ☐ Clinical notes and chart
- ☐ Gum (periodontal) charting
- ☐ Treatment plans and estimates
- ☐ Photographs and models
- ☐ Specialist letters and reports

2. For which period? ◯ Everything on file ◯ Only since: _____

PLEASE SEND THEM TO

All Care Dental
5105 Hurontario Street, Unit 6, Mississauga ON L4Z 0C9
Phone 647.479.3151

If your office sends records electronically, please phone us on that number and we will tell you where to send them.

AUTHORIZATION

Signed by the patient, or by the parent or legal guardian of a patient under 18.

I am the patient named above, or that patient's parent or legal guardian. I authorize the dental office named above to release copies of the dental records ticked above, including radiographs (X-rays), to All Care Dental at the address above.

DATE _____ SIGNATURE OF PATIENT, OR PARENT OR GUARDIAN _____

NAME OF THE PERSON SIGNING, PRINTED _____ RELATIONSHIP TO THE PATIENT _____

This form holds personal health information. All Care Dental keeps it confidential and uses it only to ask for your records. Please hand it in, at either office, rather than emailing it.