LUNAR SMILE DENTISTRY

475 Wharncliffe Rd S, London, ON N6J 2N1
226-884-2573 · info@lunarsmiledentistry.ca
lunarsmiledentistry.ca

NEW PATIENT FORM

Dental Records Release

How to return this form. Open this form in Adobe Acrobat Reader (free) to type your answers, then save it and email it to info@lunarsmiledentistry.ca. You can also print it and bring it to your first visit. Questions? Call us at 226-884-2573.

Previous dental office

Office name

Phone

Address

Email or fax (if known)

Patients

Patient full name

Date of birth

Family members whose records should also be sent:

Family member 1

Date of birth

Family member 2

Date of birth

Family member 3

Date of birth

Family member 4

Date of birth

Records to send

- ☐ Complete dental record
- ☐ X-rays and scans
- ☐ Chart and treatment notes
- ☐ Gum (periodontal) charting
- ☐ Treatment plans
- ☐ Photos and models

Authorization

I ask the dental office named above to send copies of the dental records listed for the patients named on this form to Lunar Smile Dentistry, 475 Wharncliffe Rd S, London, ON N6J 2N1. Records can be emailed to info@lunarsmiledentistry.ca. I release the office named above from liability for sharing these records as I have requested.

Signed by: ○ Patient ○ Parent ○ Legal guardian ○ Substitute decision-maker

Full name of person signing

Relationship (if not the patient)

Email

Signature

X _____

Date (YYYY-MM-DD)

Sign with the Fill & Sign tool in Adobe Acrobat Reader, or print this page and sign by hand.