ARKONA DENTAL OFFICE
P.O. Box 148
ARKONA, ONTARIO N0M 1B0

Phone: 519-828-3895 Fax: 519-828-3116
Email: info@arkonadental.com

RECORD TRANSFER FORM

To: _____

Re: _____
_____
_____

Thank you for the care you have shown the above patient(s) in the past. In order to provide them with the same continuing care, please forward the information requested below.

I authorize you to release the following information and records to the Arkona Dental Office
Date of initial exam(s)_____
_____

Date of last exams(s) _____
_____

Date of last scaling(s) and polishing(s)_____
_____

Any other recent or pertinent information_____
_____

Please mail or email any recent radiographs for the above listed patient(s) and indicate the date taken.

Thank you,

Signature of patient_____
Witness_____Date_____