Lakeshore **W**est **D**ental

3390 Lake Shore Blvd., W.
Etobicoke, Ontario, M8W 1M9
Office: 416-251-5707
www.lakeshorewestdental.com

X-RAY RELEASE CONSENT FORM

DATE**:** ___________________________

ATTN: ____________________________

TELEPHONE: ______________________ FAX: _______________________

I, ____ give authorization for

Dr.____________________________________ (previous dentist) office to release my dental x-rays to the office of;

> ***Dr. Sam Patel***
> 3390 Lake Shore Blvd. W.
> Etobicoke, ON
> M8W 1M9
> 416-251-5707
> administration@lakeshorewest.com

Please include the most current x-rays, in addition to any full mouth series, and panoramic radiograph taken within the last five years.

PLEASE FILL OUT BELOW:

LAST RECALL EXAM:____________________________________

LAST COMPLETE EXAM: _________________________________

LAST PROFESSIONAL SCALING ____________________________

LAST BITEWING'S: _______________________________________

LAST FMS: ____

LAST PANOREX: ____

Regards,

____ ______________________

signature print name