DENTISTRY 390
commissioners west

DR. TOM SREBRNJAK • DR. LORI DERKACH

REQUEST FOR TRANSFER OF DENTAL RECORDS

To: _____

_____

_____

_____

Re: _____

_____

I hereby request and authorize the transfer of my dental records to:

DENTISTRY 390
commissioners west

DR. TOM SREBRNJAK • DR. LORI DERKACH

390 commissioners road west · suite 202
london · ontario · N6J 1Y3
tel **519.660.4333** fax **519.660.4777**

Please send photocopies or email to **info@dentistry390.com** of all treatment records and all radiographs, including panorex films, from the **past two years**. Please indicate the following for each person listed above:

Date of last new patient exam_____

Date of last recall_____

Date of last bitewings_____

Date of last panorex_____

Date of last perio appointment (if applicable)_____

Thank you.

Name:_____ Date:_____

(please print)

Signature of Patient (Guardian):_____