HARBOUR CENTRE DENTAL

RECORDS TRANSFER Clear Form Print

Date: _____

Dr: _____ Phone #: _____ Fax #: _____

I hereby request and authorize the transfer of my dental records to the dental office indicated below.

Please include the following (if available):

All radiographs (full mouth series)
Copies of periodontal charting; particularly pockets, furcas and recessions
Letters and/or reports from specialists
Study models or duplicates

Please send all available records to:

Harbour Centre Dental
L19 555 West Hastings Street
Vancouver BC, V6B 4N4

(604) 669-1195
info@harbourcentredental.com

Thank you very much,

Patient (full name): _____
Date of birth: _____ Phone: _____

_____
Signature of patient or parent (if a minor)