Transfer of Records

Doctor:_____ **Phone:**_____ **Fax:**_____

I hereby authorize and request the transfer of my dental records to East End Dental.

Please include the following where applicable:

- All radiographs taken in the last two years
- Any panoramic radiograph taken in the last five years
- Copy of dental chart
- Letters/reports from specialists
- Study models

Please send all available records electronically (where possible) to the following e-mail address: **eastenddental@bellaliant.com**, or mail to:

East End Dental
65 White Rose Drive
St. John's, NL
A1A 0H5
Phone: (709) 726-7330
Fax: (709) 726-7360

Thank you,

Patient(s): **X**_____ Date of Birth: **X**_____

Signature of Patient/Guardian: **X**_____ Date: **X**_____