edgemont
dental care

Records transfer

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 surveys)
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:

Edgemont Dental Care
Dr. R. A. Varda Inc.
Suite 2 - 3046 Edgemont Blvd.
North Vancouver, BC V7R 2N4
604.985.9535

Thank you very much,

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

Phone: _____

_____

Signature (parent or guardian, if minor)

Dr. R. A. Varda Inc.
Suite 2 - 3046 Edgemont Blvd.
North Vancouver, BC V7R 2N4

telephone: 604.985.9535
fax: 604.985.9539
email: info@edgemontdentalcare.com