# X-Ray Release Form

Dear Dr. _____

Email address _____

Phone #: _____

Please forward my dental radiographs and those of any of my family members, requested here, to the office listed below.

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

*** Disclose any uncompleted treatment for this family.

*** Please provide any specialist reports that pertain to patient's history.

Thank you.

Send to: info@RidgeSquareDental.ca Please and thank you.

Ridge Square Dental

167 Jollifffe Ave. Unit 7

Rockwood, ON N0B 2K0

519-856-9191 and Fax 519-856-2418

Patient Name: _____

_____ _____

Signature of Patient, Parent or Guardian Date