



ATLANTIS DENTAL

FAMILY & COSMETIC DENTISTRY

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 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:

Atlantis Dental Cambie Village
2160 Cambie St.
Vancouver, BC V5Z 4T1

604-565-1990
cambie@atlantisdental.ca

Thank you very much,

Patient (full name): _____

Date of birth: _____ Phone: _____

Signature of patient or parent if minor