COLISEUM DENTAL CENTRE
X-Ray Transfer Request Authorization Form

Please check the box for your dental office location:

☐ Coliseum Dental Centre
3098 Carling Ave., Suite 1
Ottawa, Ontario, K2B 7K2
Phone: 613-829-4636
Fax: 613-829-4927
colisemdental@gmail.com

☐ North Gower Dental Centre
6576 4th Line Road
North Gower Ontario, K0A 2T0
Phone: 613-489-9797
Fax: 613-489-0990
northgowerdental@yahoo.ca

Date: _____

This is to authorize _____
to release my complete dental record information to Coliseum Dental Centre.

Patient's Name:

Prefix: (Mr, Mrs, Ms, Miss, Mx, Dr) _____

First Name: _____

Last Name: _____

Date of Birth: _____

Date of last initial exam:_____

Date of last recall exam:_____

Date of last bite wings:_____

Date of last panorex:_____

Please forward all information and x-rays to the office email noted above.

Patient Signature:

_____

Witness Signature

_____