Date _____

Attention _____

Patient Information Release Form

Permission is hereby granted to release information for the dental records of

_____ DOB _____

Patient's Printed Full Name

Patient's Signature

or Parent / Legal Guardian if patient is under 18 years old

Printed Name of Parent / Guardian (if applicable) _____

Relationship to Patient (if applicable) _____

Date of last complete oral exam _____ _____

Date of Bitewing _____ _____

_____ DOB _____

Patient's Printed Full Name

Patient's Signature

or Parent / Legal Guardian if patient is under 18 years old

Printed Name of Parent / Guardian (if applicable) _____

Relationship to Patient (if applicable) _____

Date of last complete oral exam _____ Date of last recall exam _____

Date of Bitewing _____ Date of last panoramic _____

Documents are to be sent to:

Dr. Susy Inoue-Cheng & Team - Flow Dental Care
418 Iroquois Shore Rd - Suite 101
Oakville ON L6H 0X7
Phone: (905) 901-1802
Email: reception@flowdentalcare.ca

Thank you,
Dr. Inoue-Cheng and Team