Dr. Michael Todd **Dr. Michael Opler**

Date: ________________________________

Previous Office Name: __________________________________
Address: ___________________________________
____
City: ___________________________________
Postal Code: ___________________________________
Phone: _______________ Fax:______________

Dear Doctor:

Regarding Patient:

I hereby give permission for originals or duplicates of **dental radiographs** and **dental information** for the above named patient/patients to be forwarded to:

Simcoe Smile Dental
936 Simcoe Street North
Oshawa, ON L1G 4W2
Phone: 905-728-2321
Fax: 905-728-3567
smile@simcoesmiledental.com

To help us with our records please indicate the following for ***each*** patient:
New Patient Exam _________________________
Panorex _________________________
Full Mouth Series _________________________
Last Recall _________________________

Sincerely,

Patient's/Parent's Signature: ____________________________________

Dentist Signature: ____________________________________