



Danforth Neighbourhood Dental Centre  
643 Danforth Ave.  
Toronto, Ontario  
M4K 1R2  
416-466-8003 Fax:416-466-8187

Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_, office # \_\_\_\_\_

Fax # \_\_\_\_\_

Please be advised that recently, \_\_\_\_\_ attended our office, and has decided to continue future treatment here.

The patient kindly requested that you forward a copy of any dental treatment records, radiographs and any other information which may be pertinent to their treatment.

Please indicate the date of the last Complete Oral Exam \_\_\_\_\_

Date of Last Bitewing X-rays \_\_\_\_\_

Date of last Panorex X-ray or Full Mouth Series \_\_\_\_\_

We thank you in advance.

Regards,

Dr. Andrew Syriopoulos & Associates

Patient Signed Request \_\_\_\_\_