CRYSTALLINE
DENTAL

Patient Consent Form

Dear Doctor:

Regarding Patient(s):
_____
_____
_____
_____
_____

I hereby give permission for originals or duplicates of dental radiographs for the above named patient(s) to be forwarded to this office:

To help us with our records please include the following dates:

New Patient Exam: _____
Panorex: _____
Full Mouth Series: _____
Last Recall: _____

Thank you for your cooperation.

Patient Signature: _____, Date:_____

CRYSTALLINE DENTAL

Dr. Robert Pacione & Dr. Fred Wauchope

Unit 1 & 2 - Major Mackenzie Road West. Vaughan, ON L6A 4R9