



339-1851 Sirocco Drive SW
Calgary, Alberta T3H 4R5

phone: 403-246-8555
fax: 403-246-8557

email: info@westmarketdental.com

(For New Patients Coming to West Market Dental)

CONSENT FORM FOR THE RELEASE OF DIAGNOSTIC RADIOGRAPHS AND / OR RECORDS FROM A PREVIOUS DENTAL OFFICE

(One Form Per Adult)

Date: _____ Dr: _____
Attention: _____

Permission is hereby granted to release information for the dental / medical
history of _____.
(Patient's Printed Full Name)

Patient's Signature: _____
(or Legal Guardian if patient is under 18)

Printed Name Of Guardian (if applicable): _____

Relationship Of Guardian To Patient (if applicable): _____

Radiographs and Records are to be sent to: Dr. Peter Lam & Associates
West Market Dental
339, 1851 Sirocco Dr. SW
Calgary, AB T3H 4R5
phone: (403) 246-8555
fax: (403) 246-8557

Specific Materials Requested: Pan if within 5 years, Bitewings if within 2 years

Printed Name Of Witness: _____
(Witness must be over the age of 18)

Signature Of Witness: _____