BANCROFT DENTAL CENTRE

68 Hastings Street North Bancroft ON K0L1C0

Tel: (613) 332-6800 Fax: (613) 332- 6808

SECTION #1: For Patient to complete

Patient Name: _____ DOB: _____

Please include the following Family Members:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

SECTION #2: For Dentist to complete

TREATMENT DATES:

Last COE: _____ _____ N/A

Last Recall: _____ _____ N/A

Last BWs: (Please email)_____ _____ N/A

Last Pan: (Please email) _____ _____ N/A

Last Scaling: _____ _____ N/A

Last Polish: _____ _____ N/A

SECTION #3 - Patient to sign and date (and/or Parent/Guardian/Caregiver)

I, the undersigned, authorize the to release my records to: Bancroft Dental Centre

Email: **bancroftdentalcentre@bellnet.ca**

Patient Signature: _____ Date: _____