

# Barrhaven Dental Care

*A healthy smile can last a lifetime*

Date:

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To Whom It May Concern:

Re:

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The above patient has come to our office for continuing dental care.  
Please forward the below information and recent radiographs regarding their dental health for our records.

**Date of last new patient examination:**

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**Date of last recall examination:**

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**Date of last prophylaxis and fluoride treatment:**

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**Date of last treatment in your office:**

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**Date of last bitewing radiographs:**

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**Date of last panorex radiograph:**

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**Outstanding treatment and referrals:**

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**Authorization:** I hereby authorize Dr. \_\_\_\_\_ to send the above particulars regarding my dental health to Dr. Shelina Amlani and associates.  
I release you from all legal responsibility that may arise from this authorization and confirm that my account is at a zero balance.

**Signature of patient/ guardian:**

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**Signature of witness:**

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Dr. Shelina Amlani & Associates  
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[smiledr@barrhavendentalcare.com](mailto:smiledr@barrhavendentalcare.com)