Iss. 9/17/08
Rev. 2/9/21

EXCELLENCE IN DENTISTRY
MAKING A DIFFERENCE, ONE SMILE AT A TIME

1523 North Market Street, Troy, Ohio 45373 937-335-4630
www.dentistintroyohio.com FAX 937-335-5174

Date _____

This is to certify that I hereby authorize to have copies of my dental x-rays / records transferred to:

Excellence in Dentistry
1523 North Market Street
Troy, Ohio 45373
(937)335-4630
Fax (937)335-5174

Please email digital x-rays to: x-ray@bentleydds.com

This authorization includes the following patient's: Birthdate:

Patient Full Name(s): _____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____

Previous dentist's name: _____
Address: _____
Phone #: _____