1523 North Market Street
Troy, Ohio 45373
1-937-335-4630

# Excellence in Dentistry

Date _____

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

**Mark T. Bentley, DDS, Inc. and Associates**
**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 #: _____

Patient (or parent) signature: _____