HAWTHORN DENTAL

PATIENT CONSENT FORM

Patient Name: _____

Date of Birth: _____

Address: _____

I, _____

hereby consent to _____

to transfer my dental records, including all bitewing, periapical and OPG radiographs to Hawthorn Dental:

reception@hawthorndentalsurgery.com.au

140A Belair Road

HAWTHORN SA 5062

Signed: _____

Date: _____