Lightship Dental
1322 Main Street
Osterville, MA 02655-1594

DATE:

TO: _____

(X) I, _____ DOB: _____, Hereby authorize you to transfer my records and most current x-rays to Lightship Dental. Please forward: FMX no more than 5 years old, latest BWX, and latest periodontal charting.

( ) I, _____ DOB: _____, hereby authorize you to make available to Lightship Dental, all the records and reports relating to my case, as specified below:

_____
_____
_____

Please forward requested information to:
Lightship Dental
1322 Main Street
Osterville, MA 02655
508-428-4929
PLEASE SEND DIGITAL X-RAYS TO: lightshipdental1@gmail.com

_____
Signed: