Lightship Dental
1322 Main Street
Osterville, MA 02655-1594

DATE:

To Dr: ______________________
Address: ______________________
____
Phone: ______________________

(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:

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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: ______________________