

Lightship Dental
1322 Main Street
Osterville, MA 02655-1594

DATE: March 18, 2022

To Dr: _____

Address: _____

Phone: _____

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: _____