U Dental
1537 Merivale Rd, Unit 1
Ottawa, ON K2G 3J3
T: 613.228.3000   F: 613.228.3080

Patient Name:

I, ____ Date of Birth ____________ give my consent for my **full dental record**, including radiographs to be transferred to:

Dr. Ahmed Sharaf
U Dental
1537 Merivale Rd, Unit 1
Ottawa, ON K2G 3J3
u@udental.ca

T: 613-228-3000
F: 613-228-3080

Please include all dental chart notes regarding procedures as well as radiographs. Please cancel all scheduled future appointments.

Thank you,

Patient Signature: ____ Date: ______________________