



Dr. D.K Mittal Dental Corporation

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Ph: (604) 566-7666 Fax: (604) 566-7660
Email: info@greenwoodsdenalBC.com

Send completed form back to us by either fax or by email to info@greenwoodsdenalBC.com

Date: _____

Name of Patient: _____

Date of Birth: _____

I hereby request that my dental records including all x-rays be transferred to Greenwoods Dental Centre:

Mail: 1128 Richards Street
Vancouver, BC V6B 3E6

Email: info@greenwoodsdenalBC.com

Please also include any recent pre-approvals received from my insurance carrier.

Signed: _____
Patient's Signature/Legal Guardian's Signature