Dr. David A. Tecosky DMD

2438 Brown Street

Philadelphia, PA 19130

Phone (215) 236-6200

Fax (215) 236-2377

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the transfer of the following records:

 Current Full mouth series x-rays or Panorex (with-in the last 5 yrs)

 Current Bite-wing X-rays (with-in the last 2 yrs)

 Any pertinent information relating to my past dental treatment

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please forward them to Dr. David A. Tecosky at the above address.

Digital x-rays can be forwarded by e-mail to tecoskydental@gmail.com

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_