

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: _____

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 _____