Iss.
Rev. 9/17/08

1523 North Market Street
Troy, Ohio 45373
1-937-335-4630

Mark T. Bentley DDS, Inc.

Date _____

This is to certify that I hereby authorize to have copies of my dental x-rays/records transferred to:

Mark T. Bentley, DDS, Inc. and Associates
1523 North Market Street
Troy, Ohio 45373
(937)335-4630
Fax (937)335-5174

This authorization includes the following patient's:	Birthdate:
Patient Full Name(s): _____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

Previous dentist's name: _____

Address: _____

Phone #: _____

Patient (or parent) signature: _____