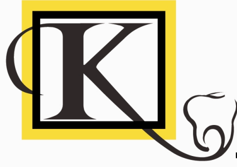

Dr. A.M. Kahane, Inc

Ph: 250-423-6838
Fx: 250-423-6839

292 – 2nd Ave, Box 2818
Fernie, BC V0B 1M0

dentist@kahane.ca
www.kahane.ca

PLEASE PRINT CLEARLY

PATIENT INFO

Name: ________________________________ Date of Birth: ________________

PREVIOUS DENTIST

Name: ____

Clinic Name: ____

City / Province: __________________________ Phone #: ___________________

Fax #: ____________________

This is to authorize permission for my Dental Records, including all x-rays, date of last recall / hygiene visit, date of last panoramic x-ray, and any information on file from other Professionals or Specialists, to be released to **Dr. A. M. Kahane Inc**. Please email all information and digital x-rays to dentist@kahane.ca and mail hard copies to Box 2818, Fernie, BC V0B 1T0.

Patient Signature: _____________________________ Date: ________________

Witness Name: _______________________________

Witness Signature: _____________________________ Date: ________________

Requesting Doctor: ____

Office Stamp: