Dental Fax Cover Sheet

Date: _____

Urgent: ☐ Yes ☐ No

Confidential: ☑ Yes

Sender Information

Dentist/Provider Name: _____

Phone: _____

Fax: _____

Email: _____

Recipient Information

Clinic Name: _____

Attention To: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

Date of Birth: ____ / ____ / _____

Patient ID (Optional): _____

Appointment Date (Optional): _____

Subject

Documents Attached

☐ Patient Records

☐ Dental X-Rays

☐ Treatment Plan

☐ Prescription

☐ Lab Request

☐ Other: _____

Special Instructions

Confidentiality Notice

This fax contains confidential patient health information intended only for the individual or organization named above. If you have received this fax in error, please notify the sender immediately by phone and permanently destroy all copies. Any unauthorized review, disclosure, copying, or distribution of this information is prohibited.

Sender Signature: _____

Date: ____ / ____ / _____