

SOUTH EDMONTON ORAL SURGERY

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Date: _____

Patient Name: _____ DOB ____/____/____
FIRST LAST D M Y

Address: _____

City _____ Postal Code _____

Phone Number: H _____ W _____ C _____

Patient Email Address: _____

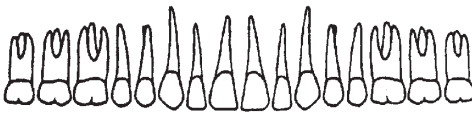
Insurance: Policy Holder Name _____

Policy Holder Date of Birth (D/M/Y) _____ Insurance Co _____

Group Plan _____ Certificate _____

Referral to: No Doctor Preference Dr. _____

Referral For: _____



18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28



55 54 53 52 51 61 62 63 64 65

PLEASE INDICATE TEETH TO BE REMOVED WITH AN X.

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38



85 84 83 82 81 71 72 73 74 75



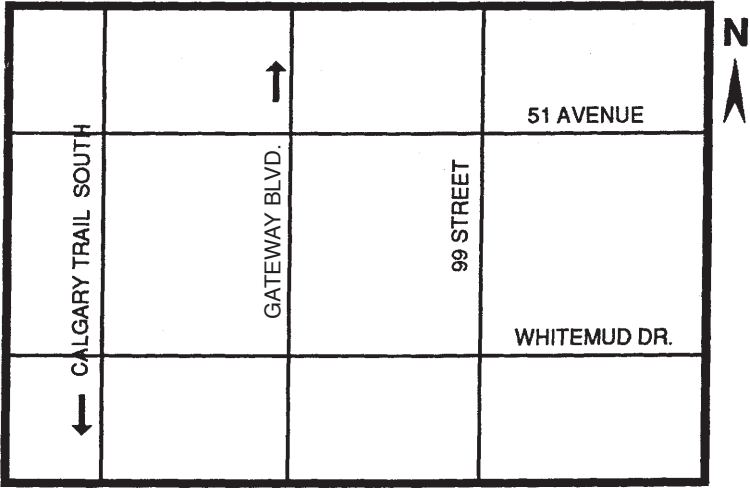
Radiographs: PAN CBCT Other Date Taken: _____

Radiographs: Uploaded Mailed Emailed Sent with Patient None Available

Referring Doctor: _____ Phone No.: _____

Clinic Address: _____ Fax No.: _____

PLEASE SEE REVERSE SIDE FOR LOCATION MAP AND PARKING INFORMATION



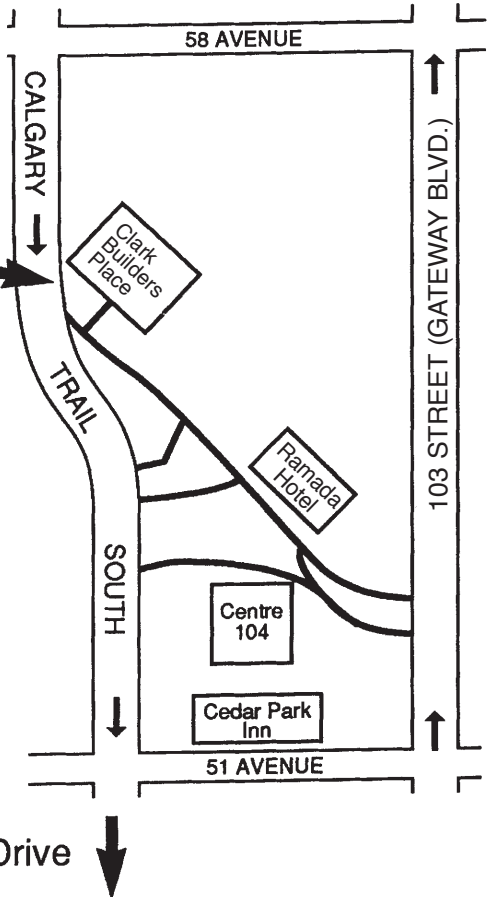
**South
Edmonton
Oral Surgery**

*Suite 100, 5555 Calgary Trail
Edmonton, Alberta*



Parking:

*Free parking is available
in the parkade to the
right of the main building
entrance. Parking is also
available on the street.*



To Whitemud Drive

