SOUTH EDMONTON ORAL SURGERY

Dr. Darrell Gotaas | Dr. Eugene Lam | Dr. Lachlan McLean | Dr. Hans Shih

Patient Demographics

Date _____

Name _____ | _____ | _____
Last First Middle

Address: _____ | _____ | _____
City Postal Code

DOB ____ | ____ | ____ Phone (primary) _____ (other) _____
dd mm yyyy

Health Care Number: _____ Contact Email Address _____

Insurance

Primary Policy Holder Name: _____ Policy holder DOB ____ | ____ | ____
dd mm yyyy

Insurance Co. _____ Group Plan _____ Certificate _____

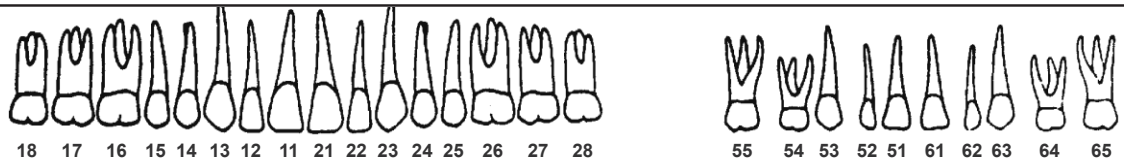
Secondary Policy Holder Name: _____ Policy holder DOB ____ | ____ | ____
dd mm yyyy

Insurance Co. _____ Group Plan _____ Certificate _____

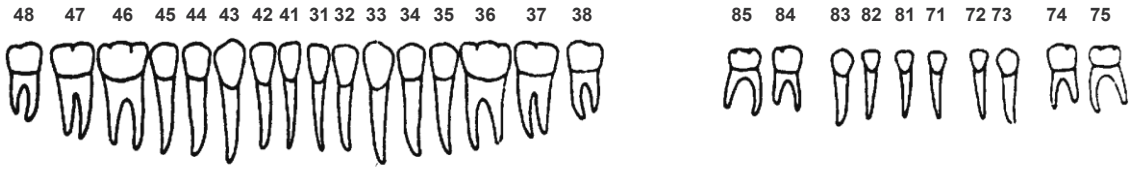
Referral

☐ **No Doctor Preference** or ☐ **Dr. Gotaas** ☐ **Dr. Lam** ☐ **Dr. McLean** ☐ **Dr. Shih**

For:



PLEASE INDICATE TEITH TO BE REMOVED WITH AN X.



Radiographs: ☐ Pan ☐ CBCT ☐ Other Date taken _____

Radiographs: ☐ Uploaded ☐ Mailed ☐ Emailed ☐ Sent with Patient ☐ None Available

PLEASE PROVIDE CLINICAL PHOTOS FOR ALL SOFT TISSUE LESIONS

Referring Clinic

Referring Doctor _____ Clinic Address _____

Clinic Phone _____ Fax _____ Clinic Email _____

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