

Date: dd / mm / yyyy

Patient's No. _____

Patient's Full Name		
Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Billing <input type="checkbox"/> Gilead Medical & Dental Centre <input type="checkbox"/> Insurance <input type="checkbox"/> Cash

REQUEST**DECLARATION**

This is to certify that the information and request stated above and furnished to you by

Mr/Mrs/Ms

is correct and it is at the request of **Gilead Medical and Dental Centre**.

Doctor's Full Name _____

Doctor's Signature
& Stamp _____

Date: dd / mm / yyyy

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