Gilead Medical & Dental Centre

AUTHENTICATION FORM

Date: dd / mm / yyyy

Patient's No.

Patient's Full Name		
Age	Gender ☐ M ☐ F	Billing ☐ Gilead Medical & Dental Centre ☐ Insurance ☐ 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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Doctor's Full Name

Doctor's Signature & Stamp

Date: dd / mm / yyyy

030 222 7196 / 030 290 4151 / 024 759 5950 / 020 748 9351 | House of Balm, No. C896/3 Kanda Highway, North Ridge – Accra. | info@gileadmedgh.com | www.gileadmedgh.com