

Dr. Gino Gizzarelli*

BScPhm, DDS, MSc (Dental Anaesthesia)

ANAESTHESIA for DENTISTRY

(416) 839-4777

Patient and Contact Information

Patient Information

Title: Mr.____ Mrs.____ Ms.____ Miss____ Dr.____ Child/Youth____

First Name _____

Middle Name _____

Last Name _____

Age _____

Date of Birth _____ / _____ / _____
Day Month Year

Address _____

City _____ Province/State _____

ZIP/Postal Code _____

Home Phone () _____

What days and times are best to contact you?

Business Phone () _____

Days _____ Times _____

Cellular Phone () _____

What is the best means to contact you by?

E-mail address _____

Contact Information

Dentist name _____

Who is the best person to contact in case of an emergency?

Name _____ Phone () _____

Relationship to you _____

Who will be responsible for taking you home after anaesthesia? **A taxi driver alone is not sufficient.**

Name _____ Phone () _____

Relationship to you _____

Employment

Employed by _____ Position _____

Insurance Information

Policy Number _____

Insuring Company _____

Subscriber Name _____ Subscriber Date of Birth _____ / _____ / _____

Certificate Number _____ Day Month Year

Medical Care Information

Family Physician: Dr. _____

Phone () _____ Fax () _____

Address _____