WELCOME TO GLOBAL DENTAL CENTRE

Thank you for choosing us as your dental service provider. In order to provide you with the highest quality of service, please try your best to answer every question in this form. If you have any questions, do not hesitate to ask our office staff!

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

- MR. ● MRS. ● MS. ● MISS

Preferred language of communication: ● English ● Mandarin ● Cantonese

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____

Date of Birth: _____/_____/_____
Day Month Year

Address: _____, _____, _____, _____
(Apmt #) Street # Street City Province Postal Code

● House ● Appartment

Home Phone: ( )_____ - _____ Work: ( )_____ - _____

Cellular: ( )_____ - _____

Email: _____

Emergency Contact: _____

Relationship: _____ Phone: ( )_____ - _____

Employer / School: _____ Occupation: _____

GLOBAL DENTAL CENTRE

BEAUTIFUL SMILES FOR LIFE

Family Physician: _____ Phone: ( )_____ - _____

Primary Insurance	**Secondary Insurance**
Subscriber: _____	Subscriber: _____
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insurance Company: _____	Insurance Company: _____
Policy/Plan #: _____	Policy/Plan #: _____
Certificate/ID #: _____	Certificate/ID #: _____
Date of Birth: _____	Date of Birth: _____
Are you familiar with your plan details? ☐ Yes ☐ No	Are you familiar with your plan details? ☐ Yes ☐ No

Who may we thank for referring you to this office? _____

Office Policy: *Your appointment time will be reserved especially for you. If you are unable to keep the appointment you will require* ***48 hours*** *notice, otherwise there will be a* ***$50.00 charge for the time lost.***

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I also had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I also give my consent to ANY advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays and blood studies. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand and acknowledge that I am financially responsible for the services provided for myself, regardless of insurance coverage. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and any fee modification.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

STAFF INITIAL: _____ DATE: _____