CENTRAL MARKHAM DENTAL CENTRE
DR. EDWARD LIU & ASSOCIATES
3085 HWY 7, UNIT 2, MARKHAM, ON L3R 0J5
T: 905-948-9999 F: 905-943-9988 INFO@CENTRALMARKHAMDENTAL.COM

Patient information In an effort to serve you better, we would ask you to complete the following. We will be glad to assist you. PLEASE PRINT.

Title: Mr. / Mrs. / Miss / Ms. / Dr. A parent or guardian will be responsible for decision on my treatment ⬭ Yes ⬭ No

Name: _____
(Last) (First) (Middle Initial)
Address: _____
(Street) (City) (Province) (Postal Code)
Date of Birth: _____ Sex: _____ Marital Status: _____ S.I.N: _____
(dd/mm/yy)
Preferred ⬭
Home Phone: _____ Work: _____ Ext. ( ) ⬭ Mobile: _____ ⬭ Others: _____

E-Mail (1): _____ Can we send appointment reminder by e-mail? ⬭ Yes ⬭ No

Employer: _____ Occupation: _____

School: _____ Student ID#: _____ Grade: _____

OHIP #: _____ Family Doctor: _____ Tel. ( ) _____

Emergency Contact: _____ ( ) Tel. ( ) _____
Relationship
How did you find out about us/Who may we thank for referring you to our office? _____

Financial Information Method of payment: Cash / Insurance / Visa/ Master Card: _____ (Exp.)

Title: Mr. / Mrs. / Miss / Ms. / Dr. Person responsible for financial matters: Self ⬭ Spouse ⬭ Parent/Guardian ⬭

Name: _____
(Last) (First) (Middle Initial)
Address: _____
(Street) (City) (Province) (Postal Code)
Date of Birth: _____ Sex: _____ Marital Status: _____ S.I.N: _____
(dd/mm/yy)
Preferred ⬭
Home Phone: _____ Work: _____ Ext. ( ) ⬭ Mobile: _____ ⬭ Others: _____

E-Mail (1): _____ E-Mail (2): _____

Employer: _____ Occupation: _____

Primary Insurance: _____

Name of Policy Holder: _____

DOB of Policy Holder (dd/mm/yy): _____

Employer: _____

Policy / Group #: _____ Div. #: _____

Certificate / ID #: _____

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the name dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature _____

Secondary Insurance: _____

Name of Policy Holder: _____

DOB of Policy Holder (dd/mm/yy): _____

Employer: _____

Policy / Group #: _____ Div. #: _____

Certificate / ID #: _____

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the name dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature _____

I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I will give 48 hours advance notice to the office if I need to cancel my dental appointment. In comply with the Canadian Anti-Spam Legislation (CASL), I authorize to receive any communications electronically.

Signature ⬭ Patient ⬭ Parent/Guardian Print Patient's Name _____ Date _____