PUSAT PERGIGIAN U 优牙科中心 U DENTAL CENTER

Family, Implant & Esthetic Dentistry®
Comfort and value™

□ Location A **Taman U 大学城:** 26 & 26A, Jalan Kebudayaan 1, Taman Universiti, 81300 SKUDAI.
Tel: 607-521 1111, 607-5208508 HP: 6014-888 9000
□ Location B **Taman Sentosa 新山大丰:** 25A, Jalan Sutera, Taman Sentosa, 80150 Johor Bahru.
Tel : 607-3333 000 HP: 6014 800 2000
□ Location C **UDA/Tampoi 新山:** 39-01, Jalan Padi Emas 1/3, Uda Business Center, Bandar Baru UDA, 81200 Johor Bahru
Tel: 607-2 444 666 HP: 6016-6 800100
□ Location D **Taman Molek 百合:** 84-01, Jalan Molek 2/2, Taman Molek, 81100, Johor Bahru.
Tel: 607-35 33 222 HP: 6019-500 8 500
□ Location E **Bukit Indah 武吉英达:** 65, Jalan Indah 16/12,Taman Bukit Indah,81200 Johor Bahru.
Tel: 607-234 2000 HP: 6014-508 0000
□ Location F **Mount Austin 奥士丁:** 70-01, Jalan Austin Height 8/7,Taman Mount Austin,81100 Johor Bahru.
Tel: 607-364 3477 HP: 6016-200 4 500
□ Location G **Masai/Seri Alam 马赛/斯里亚南:** 25-01, Jalan Suria 3, Bandar Seri Alam, 81750 Masai, Johor Bahru.
Tel: 07-253 2333 HP: 6014-803 0000
□ Location H **U Dental Specialist Clinic 优牙科专科诊所 Klinik Pakar Pergigian U:** 65A, Jalan Indah 16/12, Taman Bukit Indah, 81200 Johor Bahru. Tel: 607-234 2000 SMS: 6014-508 0000 HP: 6019-500 6 900
www.gigi.my info@gigi.my

Dear Esteemed Customers: We have few braches around JB. If the location is more convenient for you than current branch, please fill in the form below to transfer your case there. Thank you.

From:

*Patient's Name:	*Required to fill
*Date of Application to Transfer:	
*Date the transfer starting:	
*RN:	
Reason to Transfer:	

Re: Request to Change Orthodontic/Implant/Treatment Location

I/We the undersign would like to change the Orthodontic/Implant/Treatment location between two locations:

I/We request transfer from A/B/C/D/E/F/G/H (Circle where applicable) ("Original Location") to ____A/B/C/D/E/F/G/H_____ ("New Location).

I/We further agree that:

1. The terms and conditions of our previous agreement(s) remain(s) unchanged.
2. I/We request the balance of our account be transferred from the Original Location to New Location.
3. The account at the Original Location will be closed and we shall continue our Orthodontic/Implant/Treatment AND PAYMENTS at the New Location.

Thank you.

Sincerely yours,

_____

Guardian Name: _____ (If patient is less than 21 year old)

For Office Use Only: Original Location:		
Date transferred:	☐ Skype Details to New Branch for Registration	Enclosed: Models/Records/Agreement/Radiographs/Data
Balance transferred: RM	Package: □ Student Price □Adult Basic □Adult Weekends Terms : □ Cash □ CC	Prepared By : Staff Initial & Signature: Approved by Dr : □ Old deposit, if any, marked as closed
New Location:		
Patient New Registration Number at New Location:	Next Appointment Date and Time :	Completed By Staff : Name and Initials