Dr. Sue Ann Choo Dentistry Professional Corporation
56 Aberfoyle Crescent, Suite 850
Etobicoke, ON M8X 2W4

Welcome & Thank-you for Choosing Our Office!

New Patient Registration Form

Patient Information

Title: Mr. Dr. Mrs. Ms. Master Miss Last Name: _____ First Name _____

Date of Birth (dd/mm/yy) _____/_____/_____ Preferred Name: _____

Address: _____ City: _____

Province: _____ Postal Code _____

Telephone Number: (____) _____ Best Contact time: Morning Afternoon Evening

May We Contact You on your Mobile Phone: Yes Number: (____) _____ No

May We Contact You at Work: Yes Number: (____) _____ Extension_____ No

May We Contact You by Email Yes Email: _____ No

Best Number to Reach You: Home Mobile Work

Family Physician: _____ Number: (____) _____

Medical Alert / Allergies: Yes No Condition(s): _____

In Case of Emergency: Please Notify _____ Number: (____)

Please tell us how you found our office: _____

Insurance Information

Subscriber Name (if different from above): _____

Subscriber Date of Birth (if different from above) (dd/mm/yy) _____/_____/_____

Contact Number (if different from above): _____

Insurance Carrier / Company Name: _____

Group Policy Number: _____

Subscriber ID Number: _____

Eligible Members & Relationship(s): _____

_____

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If necessary, I consent to my physician being contacted regarding any specific medical question. I authorize Dr. Choo and her staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible for the dental services rendered.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Dr. Sue Ann Choo has obtained my informed consent with respect to the collection, use and disclosure of my personal health information. Upon request, I will be provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy of Dr. Choo's Office and in accordance with the *Personal Health Information Protection Act 2004.*

Date (dd/mm/yy) _____/_____/_____ Signature: _____

Medical History

Are you presently being treated for any medical condition or have you been treated within the past year?

Yes No

If yes, please explain: _____

_____

When was your last medical examination?_____

Have there been any changes in your general health in the past year? Yes No

If yes, please explain: _____

_____

Have You Ever Had or Currently Have Any of the Following:

1. A known condition: Yes No
   If yes, please describe: _____
2. Do you have or have you had:

			Heart Murmur	Yes	No	Pacemaker	Yes	No
Bleeding Problems	Yes	No	Mitral Valve Prolapse	Yes	No	Heart Transplant	Yes	No
Artificial heart Valve	Yes	No	Infective Endocarditis	Yes	No	Rheumatic Fever	Yes	No
Chest Pain	Yes	No	Heart Attack	Yes	No	Stroke	Yes	No
Shortness of Breath	Yes	No						

   If yes to any, when were you first diagnosed? _____
3. Have you ever had high blood pressure? Yes No
4. Have you ever had hepatitis, jaundice, or liver disease Yes No
   If yes, please explain: _____
5. Do you have a prosthetic or artificial joint (e.g. hip or knee surgery)? Yes No
   If yes, please explain?_____
6. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, HIV AIDS, Cancer treatment)? Yes No
   If yes, please explain: _____
7. Do have asthma? Yes No
   If yes, please describe triggers:_____
8. Do you have or have you had:

			Lung Disease	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Stomach Ulcers	Yes	No	Arthritis	Yes	No
Seizures	Yes	No	Kidney Disease	Yes	No	Thyroid Disease	Yes	No
Drug or Alcohol Dependency			Yes	No		Osteoporosis	Yes	No
Other	Yes	If "Yes", please describe:_____						No

9. Have you been hospitalized for any illness or operations? Yes No
   If yes, please explain: _____
10. Do you have any allergies to medications, latex or rubber products, or other? Yes No
    If yes, please list:_____
    _____
11. Are you taking any medication, non-prescription drugs, or herbal supplements? Yes No
    If yes, please list:_____
12. Have you ever had a reaction to local anaesthetic? Yes No
    If yes, please describe: _____
13. Has your physician ever told you to take antibiotics prior to dental procedures? Yes No
    If yes, for what reason: _____
14. Have you ever experienced complications following a medical or dental procedure?: Yes No
    If yes, please describe: _____
15. Do you smoke or chew tobacco? Yes No If yes, how much per day?_____

16. Are you nervous during dental procedures?: Yes No
    If yes, please describe _____
17. For women only: Are you breast feeding: Yes No
    Are you pregnant? Yes, Expected Delivery Date _____ No
18. Is there anything that we have not mentioned regarding your medical history that you feel would be helpful?

_____

Dental Information

Please answer all of the following:

1. When was your last dental visit? _____
   If yes, what was done at that time? _____
   Did you have X-rays taken? Yes No
2. Do you have a special reason for this visit? Yes No
   If yes, please describe: _____
3. What, if anything, has kept you from having dental treatment in the past? _____
4. Can you eat anything you want when you want? Yes No If no, please describe: _____
5. Please describe how you feel about your smile: _____
6. What has dentistry been like for you? _____
7. What do you look for most in a dental office? _____
8. How often do you seen a dentist? (____) 3, 6, or 9 months (____) yearly (____) Emergency Only

Dental Conditions (Please check all that apply)

	Present	Concern	Area / Location
Cavities	( )	( )	_____
Bleeding Gums	( )	( )	_____
Gum Infection(s)	( )	( )	_____
Shrinking Gums	( )	( )	_____
Teeth Seem Longer	( )	( )	_____
TMJ (clicks, cracks, pops, locks grates)	( )	( )	_____
Frequent Headaches	( )	( )	_____
Sensitive Teeth (hot, cold, sweet)	( )	( )	_____
Hurts to Chew	( )	( )	_____
Loose Teeth	( )	( )	_____
Food Trap Areas	( )	( )	_____
Unusual Odour and/or Taste	( )	( )	_____
Discolouration / Stain(s)	( )	( )	_____
Grinding or Clenching Teeth	( )	( )	_____
Chipped Teeth	( )	( )	_____
Worn Edges	( )	( )	_____
Abrasions	( )	( )	_____
Alignment / Spacing	( )	( )	_____

Previous Dental Treatment (Please check all that apply)

Wisdom Teeth Extracted	( )	Ortho Extractions	( )	Congenitally Missing Teeth	( )
Other Missing Teeth	( )	Gum Surgery	( )	Implants	( )
Root Canal Treatment(s)	( )	Jaw Surgery	( )	Head and/or Neck Trauma	( )
Jaw and/or Mouth Injury(s)	( )	Other	( )	If "Other", please describe:	_____