Dr. Po Fong Yang Gum Specialist

PATIENT REGISTRATION FORM

Date:	Spoken Language(s): *(Please circle)*	English, Mandarin, Cantonese, Tamil Other: _____	

(I) PATIENT INFORMATION

Title: *(Circle one)* Mr / Ms / Mrs / Miss	First Name:	Middle Name:	Last Name:
Date of Birth: (M)_____ / (D) _____ / (Y) _____		Email:	
Address:		City:	Postal Code:
Home Phone (H):	Work Phone (W):		Cell Phone (C):
Spouse's Name:		Phone Number:	
Emergency Contact Name:	Relationship to you:		Phone Number:
Family Doctor:		Phone Number:	
Family Dentist:		Phone Number:	Number of Years Seen:

(II) DENTAL INSURANCE INFORMATION

☐ No Dental Insurance

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Subscriber Employer		Subscriber Employer	
Name of Insurance Company		Name of Insurance Company	
Subscriber Date of Birth		Subscriber Date of Birth	
Policy / Group Number		Policy / Group Number	
ID / Certificate Number		ID / Certificate Number	

(III) MEDICAL HISTORY

List all medications that you are currently taking:

Date of last physical exam:	(M/D/Y)	Have you ever been admitted to the hospital for illnesses or surgeries?	☐ Yes ☐ No

Please circle any of the following conditions that apply:

Asthma	Cancers	Heart Murmur	Mental / Nervous Disorder	Seizures
Arthritis	Drug / Alcohol Addiction	Hepatitis	Mitral Valve Prolapse	Sexually Transmitted Diseases
Artificial Heart Valve	Diabetes	High Cholesterol	Osteoporosis	Skin Problems
Artificial Joints	Glaucoma	High Blood Pressure	Prolonged Bleeding	Stomach / Intestinal Problems
Anemia / Blood Disease	Heart Attack	HIV / AIDS	Rheumatic Fever	Thyroid Disorders
Chest Pain	Heart Disease	Kidney Problems	Radiation /Chemo Therapy	Tuberculosis

Do you have any allergies?	☐ Yes ☐ No
If yes, please circle:	Local Anesthetics / Penicillin / Aspirin / Codeine / Sulpha / Hay Fever / Latex Other: _____

For Women Only:

Are you currently pregnant?	☐ Yes ☐ No	If yes, when is the expected delivery date? _____	
Are you taking any birth control pills?	☐ Yes ☐ No	Are you breast feeding?	☐ Yes ☐ No

(IV) DENTAL HISTORY

Do you have to take antibiotics **regularly every time** before your dental visit?	☐ Yes ☐ No
Do your gums bleed when you brush your teeth?	☐ Yes ☐ No
Have you ever had gum surgery treatment?	☐ Yes ☐ No
Have you ever had orthodontic treatment (braces) to straighten out teeth?	☐ Yes ☐ No
Do you grind or clench your teeth?	☐ Yes ☐ No
Have you ever had your wisdom teeth removed?	☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No	If yes, how many packs/day?	When did you quit smoking?
	For how many years?	If still smoking, do you want to quit? ☐ Yes ☐ No

When was your last teeth cleaning in a dental office?	
How frequent do you usually have your teeth cleaned in a dental office?	

(V) OFFICE POLICY AND TREATMENT CONSENT

Insurance and Payment:

Payment is needed each time when dental service is provided. We will then prepare claim forms for you to submit to your insurance company. Claim forms may be sent electronically for faster processing. The degree of reimbursement varies with the insurance company and the type of coverage. Patients are personally responsible for fee payment in full regardless of the amount of insurance coverage. Other payment options are available but must be pre-arranged prior to the start of treatment. A fee is required for requesting additional copies of treatment records and x-rays.

Privacy Protection:

Protection of your private information is important in this office. The information collected here was used following the guidelines set out by Personal Health Information Protection Act (PHIPA) in Ontario.

Patient Consent and Cancellation Policy:

I, the undersigned, certify that all of the above information provided is true to the best of my knowledge. I consent to the collection and release of my personal information above and subsequent treatment record according to PHIPA. The information might be submitted to insurance companies and financial institutions for insurance processing and financial transactions. Also when needed, my records may be communicated to other treating dental and medical health-care providers and labs that are involved in the diagnosis and treatment of my conditions. I consent to the performance of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics.

Any cancellation or changes in dental appointments must be given at least 24 hours prior notice to our office. Failure to comply may result in a fee charge for no show or short notification or dismissal from our dental office.

X _____ _____

Patient Signature | Reviewed By