Galerie Dental Care

Admin use: ID Check ☐
Date: _____

Patient Information

Patient Name: _____
Last **First** **Middle Initial** **(Preferred Name)**

Gender/pronoun:_____ **Birth Date**:_____ Marital/Family Status _____

Address: _____
Street Apartment #

_____
City Province Postal Code

Phone (H): _____ (W): _____ (C): _____
(***Please circle best number to reach you at.***)

E-mail _____

Place of Work: _____ Occupation: _____ Height:_____Weight:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Referral Information

Whom may we thank for referring you to our practice?

☐Another patient, friend ☐Sign ☐ another Dental Office ☐ Yellow Pages ☐ Newspaper

☐ School ☐ Work ☐ **Other** _____

Name of person or office referring you to our practice: _____

Dental Information

Date of Last Dental Visit: _____ **Reason for last dental visit and with whom:** _____

Reason for **today's** visit: _____

Are you currently experiencing any discomfort? ☐ **Yes** ☐ **No** _____

Do you have any concerns regarding your oral health? ☐ **Yes** ☐ **No** _____

On a scale of 1-10, how happy are you with your teeth? _____

What are your goals for your teeth? **Short** Term _____

Long Term _____

Are you nervous during dental treatment? ☐ **Yes** ☐ **No** _____

Have you ever had a bad dental experience? ☐ **Yes** ☐ **No** _____

Please check anything that applies (currently or in the past)

☐ any sensitive teeth (many or single tooth)
☐ jaw soreness
☐ jaw sounds
☐ frequent headaches
☐ dentures
☐ loose teeth
☐ bleeding gums
☐ a night guard
☐ swellings in your mouth
☐ other

Please check if you are aware of any of these oral habits, or if you have been told that you do any of these things:

☐ thumb sucking
☐ toothpick use
☐ frequent gum chewing
☐ teeth grinding
☐ jaw/teeth clenching
☐ cheek biting
☐ tongue thrust
☐ mouth breathing
☐ snoring
☐ sleep apnea
☐ bulimia
☐ nail biting
☐ other oral habits

Health Information

When was your last medical checkup? _____ **Alberta Health Care#** _____
Name of Physician: _____ Phone: _____

Do you have, or have you ever had any of the following? Please check those that apply.

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Allergies to:
  -medications
  -latex
  -hayfever, food, plants
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease/ Bleeding Disorder/Excessive Bleeding
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain/ Angina
- ☐ Diabetes
- ☐ Dizziness
- ☐ Diet Pill Therapy
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease/Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Infection
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Health Conditions
- ☐ Neurological Conditions
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Prosthetic Heart Valve
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stomach Problems
- ☐ STDs
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Are there any conditions or diseases (not listed above) that you have currently or had in the past?
☐ **Yes** ☐ **No**

_____

Are you being treated for any medical condition at present, or have you been treated within the past year?
☐ **Yes** ☐ **No**

_____

Has there been any change in your general health in the past year? ☐ **Yes** ☐ **No**

_____

Are you taking any medications, non-prescription drugs, or herbal supplement of any kind? ☐ **Yes** ☐ **No**
Please list: _____

_____

Are you currently pregnant? ☐ **Yes** ☐ **No** If yes, when is the due date? _____

Are you currently breast-feeding? ☐ **Yes** ☐ **No**

Do you (or have you ever) smoke or chew tobacco products? ☐ **Yes** ☐ **No** **Daily amount:** _____
Number of Years: _____

Are there any disease or medical problems that run in your family? (Eg diabetes, cancer, heart disease)

☐ **Yes** ☐ **No** Please list: _____

Have you ever had an adverse reaction to any medicine or injections? ☐ **Yes** ☐ **No**
Please explain: _____

Have you been in hospital for any illnesses or operations? ☐ **Yes** ☐ **No** _____

Have you needed emergency care during the past two years? ☐ **Yes** ☐ **No** _____

Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ **Yes** ☐ **No**

Have you ever had any complications following dental treatment? ☐ **Yes** ☐ **No**_____
Do you have any health problems that need further clarification? ☐ **Yes** ☐ **No**_____

Patient Insurance Information:

Patients Primary Insurance Company:_____

Plan Holders name & Date of Birth: _____

Group# (Plan #)_____ **Certificate# (I.D. #)** _____

Secondary Insurance Company (if any):_____

Secondary plan holders name and Date of Birth:_____

Group# (Plan #) _____ **Certificate# (I.D. #)** _____

Regarding Your Insurance

By signing below I acknowledge and understand that insurance plans frequently change and re-imbursement levels vary greatly from plan to plan. I fully understand that some fees may exceed my plan's limitations and some services may not be covered.

Galerie Dental Care will do its best to estimate what my plan will cover based on the limited information we receive. I understand that my insurance cannot or will not divulge specific re-imbursement information to my dentist, as the contract for coverage is between me and my insurance carrier. Therefore, I acknowledge that the entire cost of my treatment is my responsibility regardless of insurance coverage. As a courtesy to me, Galerie Dental Care will accept payments directly from my insurance, but I am responsible for any balance after such payments and any costs associated with the collection of the balance.

_____ _____ _____

Signature **Print Name** **Date**

Alberta Privacy Legislation

TAKING CARE OF YOU & YOUR HEALTH INFORMATION

Our Clinic respects your confidentiality and privacy.

When you receive health services from our Clinic, we will collect individually identifying health information in accordance with (s 20) of the Health Information Act (HIA).

We will collect this health information directly from you, except in the limited circumstances where we are authorized under HIA (s 22(2)) to indirectly collect such information.

Our primary purpose in collecting your health information is to:

- Provide diagnostic, treatment and care services to you
- Determine or verify your eligibility for health services
- Bill your Dental Insurance Provider for our services

Our Clinic will only collect, use and disclose your health information in accordance with the provisions of HIA.

We will also protect your health information from unauthorized access, use, disclosure, or destruction per the privacy provisions of this legislation.

For more information, please talk to our Clinic Privacy Officer, Dr. Mahesh Kalia

Galerie Dental Care
101, 6410 50th Street
780-929-2844

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

At Galerie Dental Care we promise to provide gentle dental care in an honest, friendly and trustworthy format. We will strive to offer progressive treatment with advanced equipment and technology, in a place where patients can feel comfortable and relaxed.

Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr Rita Nijjer, Dr Mahesh Kalia and/or such associates, hygienists, and assistants as (s)he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Our Rebooking Policy

Galerie Dental Care is committed to providing all our patients with exceptional care. Please consider that your appointment has been reserved exclusively for you. When a patient cancels without giving two working days notice, it prevents another patient in need from being seen.

In order to be respectful of the needs of the community, please be courteous and call our office promptly if you are unable to attend an appointment. ***Notification of any changes must be given at least two business days prior to your scheduled appointment. If the indicated notification is not given, there will be a fee of $75.00 for the missed appointment.***

☐ ***I have read, understood and answered to the best of my knowledge and I consent to all the policies at Galerie Dental Care.***

_____ _____ **X**_____

Date **Print Name** **Signature of Patient/Guardian**

Witness _____