

**Patient Information**

Patient Name: \_\_\_\_\_

Gender/pronoun: \_\_\_\_\_ **Last** **First** **Middle Initial** **(Preferred Name)**  
**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)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> any sensitive teeth | <input type="checkbox"/> loose teeth          | <input type="checkbox"/> a night guard           |
| <input type="checkbox"/> jaw soreness        | <input type="checkbox"/> bleeding gums        | <input type="checkbox"/> retainer                |
| <input type="checkbox"/> jaw sounds          | <input type="checkbox"/> sleep appliance/cpap | <input type="checkbox"/> swellings in your mouth |
| <input type="checkbox"/> frequent headaches  |   | <input type="checkbox"/> other                   |
| <input type="checkbox"/> dentures            |   |  |

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:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> thumb sucking        | <input type="checkbox"/> cheek biting  | <input type="checkbox"/> mouth breathing          |
| <input type="checkbox"/> toothpick use        | <input type="checkbox"/> tongue thrust | <input type="checkbox"/> bulimia                  |
| <input type="checkbox"/> frequent gum chewing | <input type="checkbox"/> snoring       | <input type="checkbox"/> nail biting/ oral habits |
| <input type="checkbox"/> teeth grinding       | <input type="checkbox"/> sleep apnea   |   |
| <input type="checkbox"/> jaw/teeth clenching  |  |   |

### 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.**

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

**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

Please list any prescription medications: \_\_\_\_\_

Please list any supplements/ vitamins: \_\_\_\_\_

Do you (or have you ever) used tobacco or nicotine products (smoke, chew or vape)?

Please list: \_\_\_\_\_

Do you use any recreational drugs? Please list: \_\_\_\_\_

Are you currently pregnant?  Yes  No If yes, when is the due date? \_\_\_\_\_

Are you currently breast-feeding?  Yes  No

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-imbusement 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-imbusement 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.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

X

\_\_\_\_\_  
Signature of Patient/Guardian

Witness \_\_\_\_\_