GALLORO
DENTAL GROUP

ABOUT YOU

Today's Date: _____ MM/DD/YYYY

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Birthdate: _____ MM/DD/YYYY Age: _____

Home Address: _____ APT/CONDO #

_____
CITY PROVINCE POSTAL CODE

Phone Number: _____ E-Mail Address: _____

How do you prefer to be contacted? ☐ PHONE ☐ EMAIL ☐ TEXT

Occupation: _____ Employer: _____

Civil Status: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER

Other family members seen by us: _____

_____

_____

How did you find out about us? ☐ FRIEND/FAMILY ☐ GOOGLE ☐ RADIO ☐ INSTAGRAM/FACEBOOK ☐ OTHER _____

INSURANCE COVERAGE

PRIMARY

Insurance Co. Name: _____

Group # (Plan, Policy): _____

Insured's Name: _____

Insured's DOB: _____ MM/DD/YYYY Relation: _____

Insured's ID #: _____

Insured's Employer: _____

SECONDARY

Insurance Co. Name: _____

Group # (Plan, Policy): _____

Insured's Name: _____

Insured's DOB: _____ MM/DD/YYYY Relation: _____

Insured's ID #: _____

Insured's Employer: _____

CONTINUED ON BACK

Summerhill
(416)483-9600 • hellosummerhill@gallorodentalgroup.com
1246 Yonge Street, Suite 201, Toronto ON M4T 1W5

Don Mills
(416) 907-5888 • hellodonmills@gallorodentalgroup.com
18 Wynford Drive, Suite 703, Toronto ON M3C 1W1

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His/ Her Name: _____ Relation: _____

Work Phone Number: _____ Cell Phone Number: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ NO ☐ YES

Physician's Name: _____

Phone Number: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ NO ☐ YES

If yes, please explain: _____

Your current physical health is: ☐ GOOD ☐ FAIR ☐ POOR

Are you currently taking any are taking any blood thinners (ex. Aspirin/Warfarin/Clopidogrel)? ☐ NO ☐ YES

Are you currently taking any are taking any osteoporosis medications (ex. Fosamax/Prolia)? ☐ NO ☐ YES

Are you currently taking any other prescription/over-the-counter or herbal supplements? ☐ NO ☐ YES

If yes, please list all: _____

FOR WOMEN: Are you pregnant? ☐ NO ☐ YES, WEEK # ___

Are you nursing? ☐ NO ☐ YES

Have you ever had any of the following diseases or medical problems? (please circle)

Mental Health Conditions	Thyroid Disease (Underactive/Overactive)
Disability (Physical/Mental)	Stomach Conditions (Reflux/Ulcer)
Behavioural Conditions (ADHD/Autism etc.)	Autoimmune Disease (Ulcerative
Epilepsy	Colitis/Crohns/Lupus etc.)
Alcohol/Drug Abuse	Osteoarthritis/Rheumatoid Arthritis
Heart Problems (Heart Attack/Stroke/Angina	Kidney Conditions
etc.)	Excessive Bleeding
Rheumatic Heart Disease	Liver Conditions
Heart valve conditions/replacement valve	Blood Borne Virus (Hep B/ Hep C/HIV)
Heart Murmur	Tuberculosis (TB)
High/Low Blood Pressure	STI/STD
Stent or Pacemaker	Bone Conditions (Osteoporosis/Joint
Respiratory Conditions (Asthma/Emphysema)	Replacement)
Diabetes (Type I/II/Gestational)	Cancer/Chemotherapy/Radiotherapy
Please indicate if you weigh over 180kg (due to dental chair weight limit)	Hospitalized (for any reason)

Please list any other medical condition(s) not listed above:

_____

Have you ever had any surgeries? ☐ NO ☐ YES

If yes, please list all: _____

Are you allergic to any of the following? (please circle)

Aspirin	Dental Anesthetics	Jewelry	Metals	Tetracycline
Codeine	Erythromycin	Latex	Penicillin	

Please list any other drugs/materials that you are allergic to:

_____

DENTAL HISTORY

Why did you come to the dentist today?

_____

_____

How many times a day do you floss? _____ Brush? _____

Type of bristles? ☐ SOFT ☐ MEDIUM ☐ HARD

Do you require antibiotics before dental treatment? ☐ NO ☐ YES

Are you currently in pain? ☐ NO ☐ YES

Do your gums ever bleed? ☐ NO ☐ YES

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ NO ☐ YES

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ NO ☐ YES

Your current dental health is: ☐ GOOD ☐ FAIR ☐ POOR

Do you like your smile? ☐ NO ☐ YES

Would you like whiter teeth? ☐ NO ☐ YES

Would you like fresher breath? ☐ NO ☐ YES

Do you smoke or use tobacco in any other form? ☐ NO ☐ YES

How many units of alcohol do you consume/week? _____

Take any non-prescribed medications or recreational drugs including Cannabis (THC and/or CBD)? ☐ NO ☐ YES

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

SIGNATURE DATE

Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____

SIGNATURE DATE

Our office is Ontario PHIPA compliant and committed to meeting or exceeding the standards of infection control mandated by all regulatory bodies