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
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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

PATIENT CONSENT: FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses, (collectively referred to as "contact information").

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

Our office ensures that:

- **Only necessary information is collected about you**
- **We only share information with your consent**
- **Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols**
- **Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.**

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes to:

- **Deliver safe and efficient patient care**
- **Identify and to ensure continuous high-quality service**
- **Assess your health needs**
- **Provide health care**
- **Advise you of treatment options**
- **Enable us to contact you**
- **Establish and maintain communication with you**
- **Offer and provide treatment, care and services**
- **Communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists**
- **Allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments**

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This office will collect, use and disclose information about you for the following purposes to:

- Allow us to efficiently follow-up for treatment, care and billing
- Teach and for demonstrating purposes on an anonymous basis
- Complete and submit dental claims for third party adjudication and payment
- Comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- Comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- Permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- Allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale
- Deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- Prepare materials for the Health Professions Appeal and Review Board (HPARB)
- Invoice for goods and services
- Process credit card payments
- Collect unpaid accounts
- Assist this office to comply with all regulatory requirements
- Comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for the permission to release such information.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

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If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I consent to the collection, use and disclosure of my or child's personal information as set out above.

patient's name	signature patient, parent, or legal guardian	date dd/mm/yyyy

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