APOLLONIA DENTAL CLINIC

1936 – 38 Avenue
780.432.5842

PATIENT INFORMATION					
Patient's last name:		First:		Middle:	
Street address:			Home phone no.: ( )		Cell phone no.: ( )
City:	Province:	Postal Code:	Birth date: MM/DD/YYYY / /		Age:
Occupation:	Employer:			Work phone no.: ( )	
Email:					
How did you hear about us?: ❑ Family ❑ Friend ❑ Close to home/work ❑ Google/Social Media ❑ Other Please specify: ____________________					

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no.: ( )	Other phone no.: ( )

****Please present your dental insurance card(s) to the receptionist****

MEDICAL HISTORY

1. Do you have a family physician? ❑ **Yes** ❑ **No**

Physician Name: ________________________________ Physician/Office Phone Number: ____________________________

2. Have you ever been hospitalized, had any major operations, injuries or radiation therapy? ❑ **Yes** ❑ **No**

If yes, please specify: _______________________________________

3. Do you smoke? ❑ **Yes** ❑ **No**

If yes, please specify how much and for how long: ____

4. *For Women Only:*
Are you currently pregnant or suspect you might be? ❑ **Yes** ❑ **No**
If so, how many weeks? ______________________

Are you nursing? ❑ **Yes** ❑ **No**

5. Have you experienced unusual reactions or have allergies to any of the following?:
❑ **Penicillin** ❑ **Codeine** ❑ **Metals** ❑ **Latex** ❑ **Ibuprofen** ❑ **Other**

Please specify: ____

Patient Name: ____

6. Are you presently taking any kind of prescription or non-prescription drugs? ❑ **Yes** ❑ **No**
Do you take any **blood thinners**? ❑ **Yes** ❑ **No**

Please list all medication below (including over-the-counter drugs) **OR** bring in a medication list to your appointment:

Name of Medication (i.e. Coversyl)	Reason (i.e. High Blood Pressure)

7. Do you currently experience or have you ever had any of the following? Please check those that apply:

Cardio-Respiratory:
❑ Heart Surgery ❑ Heart Attack ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Infective Endocarditis
❑ Asthma/Difficulty Breathing ❑ Emphysema/COPD ❑ Artificial Heart Valve ❑ Congenital Heart Defects
❑ Other Heart Conditions

Hematology:
❑ Blood Transfusion ❑ Abnormal Bleeding ❑ Blood Disorder (i.e. Anemia)

Gastrointestinal/Genitourinary:
❑ Ulcerative Colitis ❑ Crohns ❑ Irritable Bowel Syndrome ❑ Hepatitis A, B, or C ❑ Stomach Ulcers ❑ Kidney Disease

Neurological/Musculo-Skeletal:
❑ Seizures ❑ Epilepsy ❑ Stroke ❑ Tendency to Faint ❑ Frequent Headaches ❑ Artificial Joints/Bones ❑ Arthritis
❑ Neuropathy ❑ Psychiatric Illness

Endocrine/Metabolic:
❑ Diabetes ❑ Thyroid Disease ❑ Frequent Infections

Head, Eyes, Ears, Nose & Throat:
❑ Injury to Head, Face or Jaw

Infectious Diseases:
❑ Sexually Transmitted Infection ❑ Tuberculosis ❑ HIV/AIDS

Other:
❑ History of Drug Abuse ❑ History of Alcohol Abuse ❑ Cancer

8. Do you have any other medical conditions not listed above that we should know about? If yes, please explain below:

____

____

DENTAL HISTORY

1. Have you had regular dental examinations in the past? ❑ **Yes** ❑ **No**

When was your last dental visit? ________________________________

What was done? ______________________________

When were your last dental x-rays taken? ____________________________

2. Have you ever had abnormal bleeding or other problems associated with dental extractions/surgeries? ❑ **Yes** ❑ **No**

3. Do you or have you ever required pre-medication for dental treatment? ❑ **Yes** ❑ **No**

If yes, please specify why: ________________________________

4. Have you ever had an unusual reaction to:

Fluoride: ❑ **Yes** ❑ **No**
Local Anaesthetic: ❑ **Yes** ❑ **No**

5. Do you have any oral habits such as clenching, grinding or nail biting? ❑ **Yes** ❑ **No**

If yes, please specify: ____

6. How often do you brush your teeth? ____

7. How often do you floss your teeth? _____________________________________

8. Are your teeth sensitive to: ❑ **Hot** ❑ **Cold** ❑ **Sweets** ❑ **Biting/chewing**

9. Do your gums bleed easily? ❑ **Yes** ❑ **No**

10. Are you having any dental pain? ❑ **Yes** ❑ **No**

11. Are you happy with the appearance of your teeth? ❑ **Yes** ❑ **No**

12. On a scale of 1 to 5, how nervous do you feel coming to the dentist

Not at all 1 2 3 4 5 Very

13. Are there any dental treatments that you are interested in? (i.e. whitening, braces, etc.)

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____

14. What dental conditions concern you at the present?

____

____

15. Please note any other conditions or important information that we should know about:

____

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This is to certify that I, the undersigned, have reported accurate information regarding my Medical and Dental History and have not knowingly misled or omitted any information. I consent to the performing of Dental and Oral Surgery procedures agreed or advised upon, including the use of local anaesthetic as indicated. I give consent to the dentists of Apollonia Dental Clinic to contact my physician if necessary.

I authorize my insurance benefits be paid directly to Apollonia Dental Clinic. I understand that I am financially responsible for any balance. I also authorize Apollonia Dental Clinic or my insurance company to release any information required to process my claims.

I fully understand the office policies and I will assume responsibility for fees associated with those procedures performed. I am aware of the cancellation fee that will be assessed, and must be paid, if I cancel or change my appointment with less than 1 business day (or less than 24 hours) notice.

Patient Name (printed): ____

Patient's Signature: __________________________________ *Date:* __________________________________