APOLLONIA
DENTAL CLINIC
1936 – 38 Avenue
780.432.5842

PATIENT INFORMATION				
Patient's last name:	First:	Middle:		
Parent/Guardian name:		Relationship to patient:		
Street address:		Home phone no.: ( )	Cell phone no.: ( )	
City:	Province:	Postal Code:	Patient's birth date: MM/DD/YYYY / /	Age:
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. Are they under the care of a family physician? ❑ **Yes** ❑ **No**

Physician Name: _____ Physician/Office Phone Number: _____

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

If yes, please specify: _____

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

Please specify: _____

4. Are they presently taking any kind of prescription or non-prescription drugs? ❑ **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. Symbicort)	Reason (i.e. Asthma)

Patient Name: _____

5. Do they currently experience or have they 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 ❑ ADHD ❑ Autism ❑ Sensory Issues

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

_____

_____

DENTAL HISTORY

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

When was their last dental visit? _____

What was done? _____

When were their last dental x-rays taken? _____

2. Have they had previous dental treatment done (i.e. fillings, crowns, extractions, etc.)? **❑ Yes ❑ No**

3. On a scale of 1 to 5, how well did they respond to previous dental examinations and/or treatments

Not Well 1 2 3 4 5 Very Well

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

5. Have they ever had an unusual reaction to:

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

6. Do they have any oral habits such as teeth grinding, thumb sucking, pacifier? **❑ Yes ❑ No**

If yes, please specify and until what age they had the habit: _____

7. How often do they brush their teeth? _____

8. How often do they floss their teeth? _____

9. Are they having any dental pain? ❑ **Yes** ❑ **No**

10. Do they do any of the following? (Please circle or check those that apply)

Snoring	Daytime mouth breathing	Night time mouth breathing
Bed wetting	Hearing deficiency	Frequent ear infections
Environmental allergies	Sleep Apnea	Speech problems

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

_____

_____

12. What dental conditions concern you at the present?

_____

_____

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

_____

_____

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: _____ *Parent/Guardian Name:* _____

Parent/Guardian Signature: _____ *Date:* _____