NEW PATIENT CHART

Legal Name: _____ _____ Preferred Name: _____ Birthdate: _____
Last First D/M/Y

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Phone Mobile: _____ Home: _____

Marital Status: ☐ Married ☐ Single ☐ Other ☐ Child

Gender: ☐ Male ☐ Female ☐ Add info

The above information is used when communicating with your insurance provider. Please ensure the information provided is the same as what your insurance provider has on file. If you would like to tell us more about your gender identify or preferred pronouns, please add below.

_____.

How did you hear about our clinic?

☐ Social Media ☐ Google ☐ Drove by ☐ Advertisement ☐ Previous patient of Dr. Caouette

Friend/Family/Co-worker (print name) _____

Doctor's referral (print name) _____

Dental Insurance

1st Insurance Name: _____ Policy/Group: _____ Certificate/ID: _____

Policy holder's name: _____ DOB: _____

2nd Insurance Name: _____ Policy/Group: _____ Certificate/ID: _____

Policy holder's name: _____ DOB: _____

Medical History

Emergency contact (name, relationship & number) _____

Family Doctor (name) _____

Medical Specialist (Name & area of specialty) _____

☐ Yes ☐ No **Are you being treated for any medical condition at present or within the past year?**

☐ Yes ☐ No **Has there been any change to your general health in the past year?**

☐ Yes ☐ No **Have you been hospitalized for illness or surgery in the past year?**

If you answered yes to any of the above questions, please elaborate below.

_____

_____

Please list any medications, non-prescription drugs or herbal supplements you are currently taking;

_____

_____

Dr. Jerome Caouette
4913 Gateway Blvd., Edmonton, AB, T6H 5C3
780.757.3723 www.southcentraldentistry.com

Check any conditions for which you have or have had in the past.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chest pain, Angina
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (B or C)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Seizures, epilepsy
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Do you have any conditions or diseases not listed above?

☐ Yes ☐ No If yes, please elaborate _____

Please list any allergies:

_____

_____

☐ Yes ☐ No **Have you ever had an anaphylactic reaction?** _____

☐ Yes ☐ No **Have you ever been told to take antibiotics prior to dental treatments?**
ie: History of Heart murmur, prosthetic heart valve, Prosthetic Joints, Mitral Valve Prolapse, Rheumatic Fever.

☐ Yes ☐ No **Are you currently pregnant, nursing or do you plan to become pregnant in the next 6 months?**

☐ Yes ☐ No **Do you smoke, vape or use chewing tobacco products?**

Dental History

☐ Yes ☐ No **Are you having any tooth or gum pain currently?**
☐ Yes ☐ No **Are your teeth sensitive to cold or hot?**
☐ Yes ☐ No **Do you clench or grind your teeth?**
☐ Yes ☐ No **Do you have any jaw joint pain?**
☐ Yes ☐ No **Do you have any dental implants?**
☐ Yes ☐ No **Have you ever had difficulty getting numb?**

Do you have any other oral health concerns? _____

☐ Yes ☐ No **Are you nervous about dental treatment?**

If yes, please rate it on a scale of 1-10. Is there a specific aspect of dental treatment that makes you nervous?

_____

How frequently do you brush your teeth? ☐ Twice a day ☐ Once a day ☐ A few times a week ☐ Seldom

How frequently do you floss your teeth? ☐ 1(+) a day ☐ 2-6x/week ☐ 1-6x/month ☐ Seldom ☐ Never

Approximately when was your last visit to a dentist? _____

If you would like us to request your previous x-rays, please provide the clinic, dentists name and phone number;

_____

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize my dentist to release my information including the diagnosis and records of treatment or examination for myself and dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.
I understand that I am financially responsible for the outstanding balance for services provided, including those that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
Patients with dental insurance understand that this office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patients' account. Patients with no dental insurance are charged directly and are personally responsible for payment of all dental services.
I understand that any fee estimate for dental care can only be extended for a period of three months from are date of the patient examination.
In consideration for the professional service rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended.
I grant my permission to you or your assignee, to text, phone or email me to discuss this statement or my treatment.
I have read the above conditions of treatment and payment and agree to their content.

Cancellation policy

We pride ourselves in providing dedicated time for each of our patients. We respect your time and make every effort to keep you from waiting by reserving time exclusively for you. We ask that you respect our time as we respect yours.

If it is necessary to cancel your appointment, we require that you provide our office with a minimum of 24 hours notice.

If you short-notice cancel your appointment or fail to show up for your appointment, we reserve the right to charge you a fee for time we have lost.

- Short notice cancellations or no-shows may be charged a fee of $50 for a hygiene appointment and/or $100 per hour for a doctor's appointment.
- After two failed appointments, we may require a booking deposit that will be applied to your appointment.
- After three failed appointments you risk being dismissed from the practice.

PATIENT SIGNATURE: _____
(or guardian)

DATE SIGNED: _____

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