Natalya Carmichael, DDS
Richard Codington, DDS

We believe in the theories of modern dental care which do not support the old premise of "When it hurts - fix it". Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for many years to come.

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A dedication to your oral healthcare.
3. The highest effort to make your visits as comfortable as possible.
4. The right treatment at the right time.
5. Fees that are fair and just for the services provided.

In return, we expect from our patients:

1. Cooperation in making and keeping appointments.
2. A conscientious effort toward good oral hygiene.
3. Preventive Care visits to maintain optimum oral health.
4. Arrangement for the payment of fees at the time of service.

In order for our relationship to be mutually satisfying and beneficial, we ask that at any time you have a question or are unhappy about any treatment, fee for service, or attitude of our dental team, please discuss it with us promptly and openly.

CANCELLATION POLICY

Because we value your time, we reserve the Doctor's and the Hygienist's time for you only. Please give at least 48 hour notice for any changes or cancellation to your appointment to avoid a service fee charge of $65.00. We thank you.

Patient Signature:____ Date:____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered to receive a copy of this office's Notice of Privacy Practices.

Patient Signature:____ Date:____________

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature:____ Date:____________

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

**AVAILABLE ON OUR WEBSITE

I have received copies of the Notice of Privacy Practices, and The Dental Materials Face Sheet from Dr. Natalya Carmichael, DDS & Richard Codington, DDS

Patient Signature:____ Date:____________

HEALTH HISTORY

Patient Name: ______________________________ **MD Physician:** ________________________

Physician Address and Phone: ____

I. Place a mark on "Yes" or "No" to answer the following questions:

☐ Yes ☐ No Is your general health good?

☐ Yes ☐ No Are you being treated by a physician now?
For What? ____________________

☐ Yes ☐ No Do you use tobacco?

Date of your last Dental Appointment? ________________

Have you taken, or currently take Bisphosphonate drugs ie: Actonel, Aredia, Boniva, Fosamax, Zometa for osteoporosis or for cancer _____**YES** _____**NO**

If Yes, Which Drug: ______________________

II. Please Check "Yes" or "No" to indicate if you have or have had any of the following:

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Anemia	❍ Yes ❍ No	Epilepsy/Seizures	❍ Yes ❍ No	Radiation Treatment	❍ Yes ❍ No
Arthritis	❍ Yes ❍ No	Fainting /Dizziness	❍ Yes ❍ No	Respiratory Disease	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Shortness of Breath	❍ Yes ❍ No
Artificial Joint	❍ Yes ❍ No	Headaches	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Skin Rash	❍ Yes ❍ No
Back Problems	❍ Yes ❍ No	Heart Attack	❍ Yes ❍ No	Special Diet	❍ Yes ❍ No
Bleeding Abnormalities with extractions or surgery	❍ Yes ❍ No	Hepatitis Type__________	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
				Swelling of feet/ankles	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Swollen Neck Gland	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Thyroid problem	❍ Yes ❍ No
Chemical Dependency	❍ Yes ❍ No	HIV Positive	❍ Yes ❍ No	Tonsilitis	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Jaundice	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Circulatory Problems	❍ Yes ❍ No	Jaw Pain	❍ Yes ❍ No	Tumor or Growth on head or neck	❍ Yes ❍ No
Congenital Heart Lesions	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No		
Cortisone treatments	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Ulcer	❍ Yes ❍ No
Cough persistent or bloody	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Weight Loss, unexplained	❍ Yes ❍ No
Diabetes	❍ Yes ❍ No	Pacemaker	❍ Yes ❍ No		
Emphysema	❍ Yes ❍ No	Psychiatric care	❍ Yes ❍ No	Women: Are you pregnant	❍ Yes ❍ No

Do you wear contact lenses? ❍ Yes ❍ No

Due Date: ______________

Any Disease or medical problems not listed on this form? ❍ Yes ❍ No

Are you nursing? ❍ Yes ❍ No

Explain: ____

III. List Medications you are currently taking:

1. ____
2. ____
3. ____
4. ____
5. ____

IV. Allergies

☐ Aspirin ☐ Local Anesthetic
☐ Codeine ☐ Penicillin
☐ Iodine ☐ Sulfa
☐ Latex ☐ Others:

____

V. DOCTOR'S NOTES

Premedication needed: Yes No

To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any changes in my health and/or medication.

Patients Signature:__________________________________ Date______________

Annual Review of Health:

Date____________ Changes________________________ Signature________________________

Date____________ Changes________________________ Signature________________________

Date____________ Changes________________________ Signature________________________

Patient's Legal Name: ________________________________ Nickname __________________________

Birth Date _______________ Age ________ Sex ☐M ☐ F SS# ________________________________

Status: ☐Married – **Spouse's** Name ___________________________ ☐Single ☐Divorced ☐Widowed

☐ **Minor**- Mom's Name: ___________________________ Dad's Name: __________________________

Address ____ City __________ State_____ Zip_________

Phone _________________________ Cell phone _______________ e-mail _________________________

☐**Full Time Employed** ☐**Retired** ☐ Full Time Student, where: ___________________________

Whom may we thank for referring you? ____

Financial Responsibility Information – Primary/Parent

Insured Name ______________________________ Birthdate _____________ SS# ___________________

Insured's Employer ____ Occupation __________________

Insurance Company ____ Phone _____________________

Group # _________________________ Subscriber ID #(if provided) _____________________________

Secondary/Spouse Information

Name ____ Cell Phone ___________________

Relation to Patient _________________________ Birthdate _____________ SS# _________________

Employed by ____ Occupation _________________

Insurance Company ____ Phone _____________________

Group # _________________________ Subscriber ID# (if provided) ____________________

AUTHORIZATION

☐ I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

☐ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

☐ If patient is a minor, Permission is hereby granted to the doctor to perform any necessary dental work for this child.

☐ If patient is an adult dependent, Permission is hereby granted to the doctor to talk to the parent/guardian regarding all dental treatment and perform any necessary dental work for this person.

Signature ____ Date _____________________