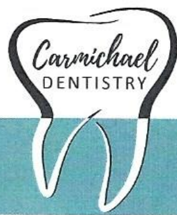


Dr. Carmichael

COSMETIC, IMPLANT & GENERAL DENTISTRY

Patient's Legal Name: ______________________________ Nickname ________________________

Birth Date______________ Age _______Sex □M □ F SS#_____________________________

Address_______________________________________ City _________State_____Zip_________

Phone ______________________Cell phone______________ e-mail _______________________

Status: □Married – Spouse's name:__________________________ □Single □Divorced □Widowed

□Full Time Employed □Retired

Whom may we thank for referring you? ____

PRIMARY INSURANCE INFORMATION

Insured Name____________________________Birthdate___________SS#__________________

Address (if different from pt.) _________________________________Phone________________

Insured's Employer____________________________________Occupation__________________

Business Address______________________________________Bus.Phone__________________

Insurance Company_____________________________________Phone ____________________

Group # _______________________Subscriber ID #(if provided) ___________________________

SECONDARY INSURANCE INFORMATION

Name ____Cell Phone __________________

Relation to Patient _______________________Birthdate___________SS#__________________

Address (if different from pt.) _________________________________Phone________________

Employed by____Occupation________________

Insurance Company_____________________________________Phone ____________________

Group # _______________________Subscriber ID# (if provided)__________________

AUTHORIZATION

□ I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

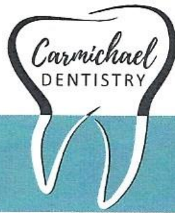
□ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

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

Responsible parent name: ____

Signature____Date ____________________

Responsible parent signature________________________________ Date ____________________



Dr. Carmichael

COSMETIC, IMPLANT & GENERAL DENTISTRY

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? ______________________

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

Condition			Condition			Condition		
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______________________

9728 Carmel Mountain Rd. Suite B, San Diego, CA 92129 • T (858) 484-2560 F (858) 484-2597 • ncarmichaeldds@gmail.com

CarmichaelDDS.com

DENTAL TREATMENT CONSENT FORM

Please read and initial the items highlighted below; also read and sign the section at the bottom of this form.

Exam ________ **X-Rays** ________ **Fluoride** ________ **Sealants** ________ **Prophy** ________ **Fillings** ________

1. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

Initials _______

2. Drugs and Medications
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction), accelerated heart rate, prolonged numbness, tingling, and/or injury to nerves that may cause pain.

Initials _______

2. Periodontal Loss (Tissue and Bone Loss)
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery replacement, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials _______

3. Crown, Bridges, and Caps
I understand that sometimes it is not possible to match the color of the teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be **before** cementation.

Initials _______

4. Fillings
I understand this office is a nonmetal practice. I understand that sometimes it is not possible to match the color my tooth exactly. Occasionally a filling may need adjusting after the initial appointment. There may be increased sensitivity after the initial placement which should subside overtime.

Initials _______

5. Removal of Teeth
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth _______________ and any other necessary for reasons in paragraph #1. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractures jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials _______

6. Endodontic Treatment (Root Canal)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy).

Initials _______

7. Dentures- Complete or Partial
I understand that full or partial dentures, are artificial, constructed or plastic, metal m and or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the **"teeth in wax"** try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Initials _______

I understand the dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I fully understand and read English. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient (Parent/Guardian if Patient is a Minor) ______________________________ Date __________

Staff signature ______________________________ Date __________