PATIENT INFORMATION

Name_____Married_____Single_____

Address_____

City_____State_____Zip_____

Birthdate_____/_____/_____Email_____

Cell_____Home_____Work_____

Employer_____SSN_____

Person Responsible for Account_____

Who may we thank for referring you to our office?_____

PRIMARY INSURANCE

Ins. Co_____

Employer_____

Name_____

SS#_____

Subscriber #_____

Date of Birth_____

Group#_____

Address_____

SECONDARY INSURANCE

Ins. Co_____

Employer_____

Name_____

SS#_____

Subscriber#_____

Date of Birth_____

Group#_____

Address_____

FINANCIAL CONSENT

I accept that payment of the total cost of treatment is my responsibility. I understand that any insurance payment estimate toward this total is not guaranteed, and acknowledge that any insurance estimates of payment are not guarantees of payment. I recognize that if I do not provide accurate insurance information the total cost of treatment is due at the time of service. I authorize my insurance payment to go directly to Signature Dentistry. I recognize that Signature Dentistry will submit my insurance claim once, and future correspondence required with my insurance company is my responsibility.

Patient Signature_____Date_____

Patient Name_____Date_____

TREATMENT CONSENT

I authorize Dr. Bennett, Dr. Khanjari, their associates and staff to perform dental treatment for me. After a thorough examination and diagnosis, I have been informed of the recommended treatment plan, and the benefits and risks involved. I have been informed of the risks of inadequate or non-treatment, and the fee.

I acknowledge that no guarantees have been made to me concerning the results of my dental treatment. As risk of failure, relapse, or worsening of my dental condition may result regardless of the efforts made during treatment. Additional treatment or retreatment is always a possibility. I recognize that long term success depends upon my cooperation and routine maintenance as well.

I specifically authorize my dentist to select alternative methods of treatment based on my condition as disclosed during the procedures, including conditions which were unknown at the time dental treatment was initiated. These additional procedures may include, but are not limited to, endodontic treatment, more extensive restorations, or tooth loss.

I understand that there are substantial risks and consequences that may be associated with any surgical, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare: Excessive bleeding, pain, swelling, infection, allergic reactions to medications and anesthetic, bruising, speech changes, food impaction areas, numbness of the lip, tongue or facial area. Knowing these risks I consent to treatment.

Patient Signature_____**Date**_____

PATIENT
NAME_____**DATE**_____

Dental History

Please Circle

Do you have a specific dental problem? Describe_____ Yes No

Last Dental Visit?_____

Have you been told in the past that you have gum disease?_____ Yes No

Do you like your smile? Why?_____ Yes No

Have you had orthodontics? _____ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint_____ Yes No

Are your teeth worn or chipped_____ Yes No

Do you smoke or chew? Any sores or growths in your mouth_____ Yes No

Do you premedicate for dental work?_____ Yes No

Medical History

Are you under a physician's care now? Why?_____

_____Who?_____Phone?_____

Have you ever been hospitalized or had a major operation?_____

Are you taking any medications?_____

Do you get frequent headaches?_____Yes No

Do you snore?_____Yes No

Have you ever taken a sleep test?_____Yes No

Do you wear a CPAP?_____Yes No

History of Cancer_____type_____date of last treatment_____

Allergies: Aspirin Penicillin Codeine Acrylic Metal Latex/Rubber Other

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING (Circle Y or N)

Heart Disease Y N	Rheumatic Fever Y N	Bacterial Endocarditis Y N
Heart Murmur Y N	Artificial Heart Valve Y N	Coronary Bleeding Y N
Irregular Heart Beat Y N	Pace Maker Y N	Lung Disease Y N
Angina Y N	Pulmonary Stint Y N	Breathing Problems Y N
Mitral Valve Prolapse Y N	High Blood Pressure Y N	Frequent Cough Y N
Scarlet Fever Y N	Low Blood Pressure Y N	Hay Fever Y N
Asthma Y N	Liver Disease Y N	Tumors/Growths Y N
Emphysema Y N	Hepatitis Y N	Psychiatric Care Y N
Tuberculosis Y N	Kidney Problems Y N	Alzheimer's Disease Y N
Cancer Y N	Thyroid Disease Y N	Taking ADHD meds .Y N
Chemo/Radiation Y N	Parathyroid Disease Y N	Epilepsy/Seizures Y N
Osteoporosis Y N	Pain in the jaw joint Y N	AIDS Y N
Bisphosphonates Y N	Fainting/Dizziness Y N	HIV positive Y N
Osteonecrosis of Jaw Y N	Alcoholism/Addiction Y N	Convulsions Y N
Aredia IV/Reclast IV Y N	Zometa IV Y N	Diabetes Y N
Fosamax, Actonel, Boniva Y N		

Any other Illness, Condition, Allergy or Medication not listed here?_____

Do you wish to talk to the dentist privately about any problem?_____

To the best of my knowledge, all of the preceding answers are correct. I f I have any changes in my health status or if my medications change, I will inform the dentist and staff at the next appointment without fail.

X_____DATE:_____

Patient Signature or Guardian

Dr. David S. Bennett & Dr. Hamid R. Khanjari

PATIENT AUTHORIZATION TO DISCUSS AND RELEASE PROTECTED HEALTH INFORMATION WITH OTHER INDIVIDUALS

The Health Insurance Portability Act of 1996 (HIPAA) prohibits this office from discussing a patient's care and/or account information with other individuals. For this reason, your permission is needed if you want your medical/account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or guardian.

I, _____ hereby authorize Signature Dentistry of Aurora and staff to contact and discuss my medical and/or financial information with the following person(s).

Name:	Relationship:	Phone Number:	Medical:	Account:
_____	_____	_____	Y/N	Y/N
_____	_____	_____	Y/N	Y/N
_____	_____	_____	Y/N	Y/N

_____ _____

Patient/Guardian Printed Name Date of Birth

_____ _____

Patient/Guardian Signature Date

CONSENT FOR USE OF E-MAIL COMMUNICATION

In an effort to communicate in a more timely and efficient manner, Drs. Bennett & Khanjari, Signature Dentistry of Aurora may utilize unencrypted e-mail messages, including radiographs, to your referring and/or treating Dentists and Physicians.

Drs. Bennett & Khanjari and staff will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, communication sent over an unencrypted e-mail system may not be secure and there is no assurance of confidentiality of information when communicated this way. Drs. Bennett & Khanjari will not be held liable for improper disclosure of confidential information over e-mail.

I acknowledge that I have read and fully understand the Consent for Use of E-mail Communication form. I understand the risks associated with allowing the communication of e-mail amongst my providers. I AGREE to allow Drs. Bennett & Khanjari and/or staff to communicate via e-mail to my referring and/or treating dentists and physicians.

_____ _____

Patient/Guardian Signature Date

_____ I **DO NOT** wish for Drs. Bennett & Khanjari and/or staff to communicate via e-mail with my referring and/or treating Dentists and Physicians.