

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. If 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

