SMILE COLORADO

COSMETIC, RESTORATIVE & IMPLANT

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	SECONDARY INSURANCE
Ins. Co_____	Ins. Co_____
Employer_____	Employer_____
Name_____	Name_____
SS#_____	SS#_____
Subscriber #_____	Subscriber#_____
Date of Birth_____	Date of Birth_____
Group#_____	Group#_____
Address_____	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 Smile Colorado. I recognize that Smile Colorado will submit my insurance claim once, and future correspondence required with my insurance company is my responsibility.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Treatment Consent

☐ I authorize Dr. Bennett, Dr. Huebner, 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 Name: _____ Date: _____

Patient Signature: _____ Date: _____

Dental History

Please circle either "Yes," or "No" for the following questions:

Do you have a specific dental problem? If yes, please describe. **YES** **NO**

_____

Date of last dental visit? _____

Do you like your smile? **YES** **NO** Why? _____

Have you had orthodontics? **YES** **NO**

Do you ever have clicking, popping, or discomfort in the jaw joint? **YES** **NO**

Do you smoke or chew? Any sores or growths in your mouth? **YES** **NO**

Do you take antibiotics before dental work? **YES** **NO**

Medical History

Are you currently under a physician's care? If yes, please explain why.

_____

_____

Name of physician: _____ Physician phone #: _____

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

Please list any prescription or over-the-counter medications you are currently taking: _____

_____

Do you experience 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? _____ **YES** **NO** Type: _____ Date of last treatment: _____

Allergies

Please circle all that apply.

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex/Rubber
- Other: _____

Please circle "Y" or "N" if you have ever experienced the following:

Heart Disease	Y / N	Rheumatic Fever	Y / N	Bacterial Endocarditis	Y / N	Scarlet Fever	Y / N
Heart Murmur	Y / N	Artificial Heart Valve	Y / N	Angina	Y / N	Low Blood Pressure	Y / N
Coronary Bleeding	Y / N	Irregular Heartbeat	Y / N	Pulmonary Stint	Y / N	Hay Fever	Y / N
Pace Maker	Y / N	Lung Disease	Y / N	Breathing Problems	Y / N	Asthma	Y / N
Mitral Valve Prolapse	Y / N	High Blood Pressure	Y / N	Frequent Cough	Y / N	Liver Disease	Y / N

Please circle "Y" or "N" if you have ever experienced the following:

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 jaw joint	Y / N	AIDS	Y / N
Bisphosphonates	Y / N	Fainting/Dizziness	Y / N	HIV Positive	Y / N	Osteonecrosis of Jaw	Y / N
Substance use disorder	Y / N	Convulsions	Y / N	Aredia IV/Reclast IV	Y / N	Zometa IV	Y / N
Diabetes Type 1	Y / N	Diabetes Type 2	Y / N	Fosamax, Actonel, Boniva	Y / N	Artificial joints	Y / N
Blood Thinner Medication	Y / N	Acid Reflux	Y / N				

Any other illness, condition, allergy or medication that is not listed here?

_____

_____

Do you wish to speak with the dentist privately about a problem you are experiencing?

_____

_____

By signing below, I confirm 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.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Health Information Release for Patients Authorization

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 the doctors and team of Smile Colorado to contact and discuss my medical and/or financial information with the following person(s):

SMILE COLORADO

COSMETIC, RESTORATIVE & IMPLANT

Health Information Release for Patients Authorization

Please provide contact details for the person(s) Smile Colorado may contact to discuss medical and/or financial information below.

Name:	Relationship:	Phone Number:	Medical:	Financial:
			Y / N	Y / N
			Y / N	Y / N
			Y / N	Y / N

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

E-Mail Communication Patient Consent

In an effort to communicate in a more timely and efficient manner, Drs. Bennett & Huebner, and the team at Smile Colorado may utilize unencrypted e-mail messages, including radiographs, to your referring and/or treating Dentists and Physicians.

Drs. Bennett & Huebner 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 & Huebner 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 & Huebner and/or staff to communicate via e-mail to my referring and/or treating dentists and physicians.

Patient Signature: _____ Date: _____

_____ I **DO NOT** wish for Dr. Bennett and Dr. Huebner and/or staff to communicate via e-mail with my referring and/or treating dentists and physicians.