



Bennardi, Barberio
42 S Main St, Muncy PA 17756

PATIENT INFORMATION

Name _____
Preferred Name _____
Address _____

Home Phone _____
Cell Phone _____
Work Phone _____
Employer _____
School Name (if full time student) _____
Dental Insurance Co _____
Subscriber # _____
Group # _____

Best Time to Schedule Appointments (Please Circle all that apply) **DAYS:** MONDAY TUESDAY THURSDAY FRIDAY

FAMILY INFORMATION

Fill in Both Father and Mother for Minor Child

Father (or Husband)

Name _____
Address _____
Home Phone _____
Cell Phone _____
Work Phone _____
Date of Birth _____
Social Security # _____
Employer _____
Dental Insurance _____
Group # _____
E-Mail _____

___Married___Single___Minor
___Male___Female
Date of Birth _____
Social Security # _____
Whom may we thank for referring you to our office?

E-mail address _____

CONTACT-IN CASE OF EMERGENCY

Outside of Immediate Household/Family

Name _____
Address _____
Phone _____

TIMES: EARLY AM (7:30 – 9:30) EARLY PM (1:00-3:00)
LATE AM (9:30-11:30) LATE PM (3:00-4:15)

AUTHORIZATION

I hereby authorize payment directly to Bennardi, Barberio of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals.

X _____
___Adult Patient ___Father (Or Husband) ___Mother (Or Wife) ___Guardian

Mother (or Wife)

Name _____
Address _____
Home Phone _____
Cell Phone _____
Work Phone _____
Date of Birth _____
Social Security # _____
Employer _____
Dental Insurance _____
Group # _____
E-Mail _____

SERVICE CHARGE

I understand that if I do not pay my entire balance within 25 days of the monthly billing dated, an interest charge will be added to my account. The interest charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default or payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding balances.

X _____
___Adult Patient ___Father (Or Husband) ___Mother (Or Wife) ___Guardian



Bennardi, Barberio
42 S Main St, Muncy PA 17756

Patient Name

Physician:

Physician Phone:

Pharmacy:

Pharmacy Phone:

Primary reason for this dental appointment? _____

DENTAL HISTORY

Please answer the following about your dental history. Please explain your answers.

<input type="checkbox"/> Y	<input type="checkbox"/> N	Brush regularly	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	Gum disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bruxing	_____	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chew tobacco	_____	<input type="checkbox"/>	<input type="checkbox"/>	Negative dental experiences	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decay	_____	<input type="checkbox"/>	<input type="checkbox"/>	Nice Smile	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Positive dental experiences	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dental X-rays regularly	_____	<input type="checkbox"/>	<input type="checkbox"/>	Smoke cigarettes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Floss regularly	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Alcohol Use	_____
<input type="checkbox"/>	<input type="checkbox"/>	Food Traps	_____	<input type="checkbox"/>	<input type="checkbox"/>	TMJ problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Grinding	_____	<input type="checkbox"/>	<input type="checkbox"/>	Visit dentist regularly	_____
Specific Dental Problems:		_____		<input type="checkbox"/>	<input type="checkbox"/>	Want to keep remaining teeth	_____

MEDICAL HISTORY

If female please answer the following:

<input type="checkbox"/> Y	<input type="checkbox"/> N	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

Height _____

Weight _____

Office Use Only

BP	Heart Rate
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ALLERGIES

<input type="checkbox"/> Y	<input type="checkbox"/> N	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Acrylic
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
Other		_____

MEDICATIONS

Name	Dosage	Frequency	Doctor

Dates of Hospitalizations and/or major surgeries:

Are you currently under a doctor's care? Please explain.

Patient Name:

Office Use Only:

[Empty box for Patient Name]

Medical Alerts [Empty box for Medical Alerts]

Do you now have or have you ever had any of the following? Please explain if you answer yes.

If you have any of the conditions in bold please call our office prior to your appointment you may need to premedicate.

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hive or Rash
<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Injury to head or neck
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the limbs
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Under doctors care
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>	X-ray Treatments (Radiation)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice

Other serious illness not listed _____

To the best of my knowledge, all of the preceding answers on both pages are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Signed: _____ Adult Patient ___ Father (or Husband) ___ Mother (or Wife) ___ Guardian

Bennardi, Barberio PC
**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have read the notice and/or received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Bennardi Barberio, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (03/30/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner, and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.10 for each page, \$10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Thomas Barberio, DMD

Telephone: 570-546-3419

Fax: 570-546-7172

E-mail: bennardibarberio@comcast.net

Address: 42 S Main St, Muncy PA 17756



BENNARDI, BARBERIO, P.C.

42 S. MAIN ST.

MUNCY, PA 17756

DEAR PATIENT,

You may be asking yourself, "Why does it seem like I fill out paperwork every time I come to the dentist?" Well, our office philosophy about patient care and communication is to keep you informed about any changes that affect your care from new technologies to new fees. We want you to feel well informed regarding all phases of your care and answer any questions you may have regarding treatment. Because dental technology constantly changes, we continuously educate ourselves on the new offerings and decide what would be best for you. This means we are instituting new ideas, equipment, and methods of care on a regular basis – at least several times a year. We have a limited amount of time to spend with you when we see you, and we would like to spend the bulk of that time concentrating on your dental health and the reason for your visit. Taking several minutes to read and sign paperwork prior to your appointment allows us to spend more time with you. We hope that you understand the need for this, and we appreciate your cooperation.

The two forms that you are viewing today are regarding our financial policy and anesthesia/chlorhexidine. The financial policy information is not new, nor has it changed rather, we are providing everyone with a copy to read and evaluate. We understand the roll that finances often plays in the dental care patients chose for themselves. We hope that having the information and options available now may help patients plan for their long-term dental care and help them to create dental health goals. We apologize in advance to our patients who have been with us for many years and previously did not receive this information in writing. In today's society, it is recommended that we provide this information to you. We do not want to overlook anyone, and are distributing it to everyone.

The handout regarding anesthesia provides you with information about the risks involed with anesthesia during dental treatment. You will be informed prior to anesthesia being given. Please note – we do not provide sedation. The anesthesia we use is local anesthesia and is placed in the area that will be treated. Local anesthesia has the same risk factors and is the same medication used for the last 15 years. Chlorhexidine is an antibacterial rinse that is used during various treatments in our office. New equipment in our treatment rooms enables our hygienists to use this rinse with our ultrasonic scalers. As plaque is loosened from your gum tissue and tooth structure, the area is rinsed with this medication. It helps to kill the bacteria that cause gingivitis, bleeding, and bone loss. Chlorhexidine is a prescription medication and we will inform you if we plan to use it during treatment. There is no extra charge if the medication is used. We ask that you sign this paper so that we may use this if necessary.

We thank you for your continued cooperation and allowing us to be your dental care professionals.



Bennardi, Barberio, P.C.
42 S. Main St.
Muncy, PA 17756
570-546-3419
570-546-7172 Fax
bennardibarberio@comcast.net

January 19, 2012

Dear Valued Patient,

We are dedicated to providing you with the best possible treatment and care. As always, we are happy to discuss our services and policies with you. It is important to our professional relationship that you clearly understand our financial policy. Please ask if you have any questions about our fees, policies, or your responsibility.

The following is an overview of our financial policy. We ask that you review this and then sign it, verifying that you have read and understand our policy.

FINANCIAL POLICY

For our patients with dental insurance:

We will continue to aid you by processing your insurance claims to maximize your benefits, and submit to those carriers who remit directly to us. You continue to be responsible for the payment of the **estimated portion of your bill** at the time of service. Please be aware that we **cannot guarantee** that the procedures you are having done at any time will be covered by your insurance plan. You will be responsible for additional balance that may be due after the insurance portion has been received by our office. If you have questions about the portion that your insurance will cover, we ask that you contact your insurance carrier or benefit handbook prior to your appointments. Further, we ask that if you are not prepared to pay your balances or co-pays at the time of service that you reschedule your appointment. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT in addition to cash, checks and debit cards with the VISA and MASTERCARD logo. We will bill your insurance carrier for 60 days for any service. After that time, the balance will be billed to the patient.

When arriving at our office, please notify us if you have had any changes in name, address, phone number, employer, or insurance carrier. With the industry changes due to HIPAA, insurance companies are issuing new employee identification numbers, so please let us know when you receive your new card. It is also very important that we have a social security number on file for every member of your family including children also for HIPAA regulations.

For our patients without dental insurance:

Patients without insurance are responsible for the cost of treatment at the time of service. In addition to cash and checks, we accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT. We can process debit cards with the VISA or MASTERCARD symbol on them. We ask that if you are not prepared to pay for your services at the time of treatment that you reschedule your appointment.

When arriving, please notify us of any changes in name, address, phone number, or employer. We do need to have a social security number on file for all members of your family as part of the HIPAA regulations.

For all patients:

Please note that we continue to charge 1.5% monthly (18% APR) on all balances not paid within 30 days. If you are having treatment that is more extensive, and wish to discuss additional payment options, please ask a member of our business staff.

A 24-hour notice is required for cancellation of appointments. Any appointments cancelled with less than 24 hours notice are subject to a \$75 missed appointment fee.

Again, if you have any questions about this or any other policies please ask. We are here to help you, and provide you with high quality dental care.

Signature of Patient/Responsible Party

Date



Bennardi, Barberio, P.C.
42 S. Main St.
Muncy, PA 17756
570-546-3419
570-546-7172 Fax
bennardibarberio@comcast.net

INFORMED CONSENT

LOCAL ANESTHESIA & CHLORHEXIDINE

I give my consent to Dr. Mary C. Bennardi/ Dr. Thomas F. Barberio to use local anesthetics that the dentist may deem necessary or advisable to enable the providers of service to render dental treatment as indicated on my examination chart, which I acknowledge by my signature below has been previously explained to me. I also give consent for any dentist or hygienist to irrigate the mouth during preventative maintenance with the prescriptive rinse Chlorhexidine and/or Povidone/Iodine. Please notify your provider if you have an allergy to iodine. When necessary, these rinses are used to help fight against the bacteria which causes periodontal disease. Additionally, any other procedure deemed necessary or advisable as a corollary to the planned treatment for the below named individual, with the exception of: (if none, so state)

List Exceptions:

I have been informed and understand that occasionally there are complications involved in this type of treatment and/or the use of these types of anesthesia agents: including, but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, nerve damage, stroke or cardiac arrest. I further understand and accept that complications may require hospitalization and may even result in death.

I agree that the doctor has discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the preoperative and post-operative instructions. The treatment and anesthesia procedures have been explained to me to my satisfaction, along with the possible alternative methods and their advantages and disadvantages, risks, consequences and probable effectiveness of each as well as the prognosis if no treatment is provided.

Patient Signature _____ Date _____

Witness _____



Bennardi, Barberio, P.C.

42 S. Main St.

Muncy, PA 17756

570-546-3419

570-546-7172 Fax

bennardibarberio.comcast.net

INFECTION CONTROL

This information is provided to inform you about measures we have taken in our office to reduce the chances of cross-contamination of disease from patient to patient. You will note numerous areas of prevention you may not have seen before. Included among them are:

1. **Facemasks:** All our clinical personnel wear facemasks during active patient care. These physical barriers assist in reducing the spread of organisms from person to person.
2. **Gloves:** New rubber gloves are worn for every patient. These gloves assure you of no contamination from other patients.
3. **Disinfection of Counters and Other Surfaces:** You may notice a mild chemical odor associated with wiping surfaces. These chemicals are necessary to disinfect surfaces that are touched during patient treatment.
4. **Items Attached to Dental Operating Units:** Handpieces, air blowers, suction equipment, etc. are sterilized by a combination of heat and chemicals.
5. **Barriers:** Plastic, rubber or paper is placed on switches, etc. for each new patient.
6. **Instruments:** All metal instruments placed in your mouth have been sterilized by a combination of heat and chemicals. All plastic items are new for each patient.

We assure you that every precaution is being taken to avoid any cross-contamination from patient to patient. We welcome your suggestions.

Thank you.