



TOTAL HEALTH SLEEP SOLUTIONS, INC.

87 S. McLean Blvd., Suite B – South Elgin, IL 60177 – P: 847.888.8311 - F: 847.429.9334

Release for Non-Dental Patient

Patient Name _____ DOB _____

I understand that I am seeking treatment with Total Health Sleep Solutions, Inc., Dr. Anthony R. Bennardo, and other associated affiliates for the purpose of a sleep orthotic appliance only. I understand that I am not a dental patient-of-record with Dr. Anthony R. Bennardo.

The importance of regular dental care has been explained to me and I understand that Dr. Anthony R. Bennardo will not be responsible for providing my preventive or emergency dental needs. At this time, I choose to have my routine and necessary dental care completed at another office.

I understand that regular recall appointments and preventive care should be kept with my general dentist. Dr. Bennardo has recommended that for the first year, at least, these recall and preventive appointments should be scheduled every three (3) to six (6) months in order to closely monitor my dental health, oral hygiene and periodontal health.

I also agree to allow Total Health Sleep Solutions, Inc. to share with my dentist any information deemed necessary for the treatment of my sleep apnea with an oral appliance.

Dentist Name _____ Phone _____

Address _____

City _____ State _____ ZIP _____

By signing below, I agree to the above statements.

Signature _____ Date _____