Bhat & Associates

Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

Patient Information

Patient's Full Name: _____ Preferred Name: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____

Referred by: _____
Insurance Carrier: _____ Policy #: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Suscriber Social Security #: _____ Group #: _____
Carrier Address: _____
Carrier Phone #: _____

Please list all persons who may schedule appointments or call for medical advice (i.e. grandparents, neighbors, etc). These individuals will be asked to present identification at the time of the visit. If someone other than these persons contacts us about you, we will contact you for permission to treat or advise.

Be advised that the persons who are listed by you have been authorized by you to make medical decisions for you, to give additional information about health history if required, discuss treatment needs, and give permission for changes to the treatment plan if required. If you do not feel comfortable allowing the persons listed to authorize and make needed decisions with regard to your treatment, please do not list them below.

Name	Relation	Phone #

This authorization will remain in effect until revoked by me in writing. Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

I certify that all the above Patient Information is correct.

_____ _____
Signature Date

Bhat & Associates

Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

Adult Health History

Patient Name: _____

Name of your physician: _____ Date of last physical exam: _____

Are you pregnant or could be pregnant? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Are you in good health? ☐ Yes ☐ No

Have you ever had a health problem? ☐ Yes ☐ No

If so, please describe: _____

Have you ever been hospitalized? ☐ Yes ☐ No

If so, please give reason & dates: _____

Are you allergic to anything? ☐ Yes ☐ No

If so, please describe: _____

Are you currently taking any medications? ☐ Yes ☐ No

Please give medication, dose & reason: _____

Please check if you have been treated for any of the following:

☐ Adverse drug use	☐ Cerebral palsy	☐ Heart disease	☐ Physical delays
☐ AIDS/HIV	☐ Cleft lip/palate	☐ Hepatitis	☐ Recurrent headaches
☐ Anemia	☐ Congenital birth defects	☐ Joint replacement	☐ Rheumatic fever
☐ Asthma/breathing	☐ Diabetes	☐ Kidney disease	☐ Seizures
☐ Autism	☐ Endocrine/growth	☐ Liver/GI disease	☐ Significant injuries
☐ Bleeding/transfusions	☐ Eyesight	☐ Mental delays	☐ Speech/hearing
☐ Blood dyscrasias	☐ Frequent infections	☐ Personality/social	☐ Other problems
☐ Cancer/tumors	☐ Heart attack		

Please elaborate on any items checked: _____

_____

Dental History

Have you ever been to the dentist? ☐ Yes ☐ No Name of dentist and date: _____

Have you experienced any unfavorable reaction from previous dental care? ☐ Yes ☐ No

If so, please explain: _____

Please check if you are having problems with any of the following:

☐ Cavities	☐ Orthodontics	☐ Gum Infections	☐ Teeth Sensitivity	☐ Other
☐ Trauma	☐ Toothache	☐ Jaw Sounds	☐ Color of teeth	

Comments: _____

_____

Consent for Dental Treatment

I certify that all information I have entered above is correct. I request and authorize the doctor to examine, clean, and provide dental treatment on my teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctor to diagnose and/or treat my dental problem.

_____ _____

Signature Date

Bhat & Associates
Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

Informed Consent For Treatment

Initial Visit: I understand that during my first visit a thorough examination will be completed. This exam may include necessary x-rays as well as the use of other aids, which may be necessary in order to make an accurate diagnosis of the condition of my mouth, teeth, and gums. In most instances, my dental condition will be determined at this visit and a suitable treatment plan will be discussed with me. In order to help formulate treatment recommendations the following diagnostic procedures may be performed: (1) medical and dental history (2) discussion of my dental problems and my concerns and desires for treatment (3) x-rays (4) examination of the mouth and supporting structures (5) conference with previous concurrent health professionals. If additional diagnostic procedures or consultations are indicated they will be discussed with me.

Treatment recommendations: I understand that treatment recommendations are based on information gained from initial diagnostic procedures. The ultimate goal of treatment is to assist me in attaining optimum dental health. The office of Bhat & Associates will discuss with me the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. The office of Bhat & Associates will also inform me of the likely dental prognoses for each of these treatment plans and the prognosis if no treatment is initiated at this time. I understand that I am welcome at any time to seek a second opinion and will be provided any necessary information needed, including - but not limited to - x-rays.

Anesthetics: I understand that most restorative procedures are preformed under localized anesthesia (commonly referred to as Novocain or Lidocaine). In addition, other sedative medications can assist to minimize anxiety and discomfort. In rare instances, allergic reactions my occur. Therefore, I have been requested to inform the staff of any known allergies I may have. Some of these sedative medications can cause drowsiness. When these medications are used I would need to make appropriate arrangements for myself.

Medical History: I understand the medical and dental history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the dentists, dental associates or designated staff members of any changes in my health or medication prior to treatment.

Treatment: Upon such diagnoses, I authorize the dentists, dental associates or designated staff members to perform all recommended treatment mutually agreed upon. I understand that during the course of the my dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on my treatment plan, and that I will be consulted prior to initiation of treatment procedures that are not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of dental treatment that the I receive in the office of Bhat & Associates.

Informed Consent and Authorization: I certify that I have read and understand this informed consent, which outlines the general treatment considerations and potential problems or complications of dental treatment. I understand that potential complications and problems may include but are not limited to: the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I have had sufficient opportunity to discuss my dental condition/problem(s), the planned procedures and treatment, alternative approaches and/or no treatment. I understand that during and after the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment procedures. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff.

Procedure for revoking consent: I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

Payment: Lastly, I understand that payment above and beyond the estimated insurance coverage amount is payable at the time treatment is rendered. I authorize payment of any insurance benefits directly to Bhat & Associates. I authorize release of any information relating to dental insurance claims.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Witness Signature Date

Bhat & Associates
Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

Financial Policy

The office of Bhat & Associates is a General Dentistry Practice devoted to your dental care. Prior to initiating treatment-planned work, a treatment estimate will be available to the insured upon request. It is the responsibility of the insured to contact their insurance carrier or our office prior to their visit to inquire whether we are in-network or out-of-network. The insured should be aware that this office may not be an in-network provider with your carrier even though your in-network general dentist referred you to this office. Treatment decisions by any of our dentists are not made based on your insurance carrier or plan, but rather your best interest and normal standard of care. Our estimates are generated by our computer software based on information it has collected from plans similar to your plan. Our office has no way of knowing exact payments until your insurance carrier sends a pre-estimate of benefits to our office or an explanation of benefits with payment is received, unless we are contracted with your carrier.

If treatment is rendered prior to receiving this information, the insured must be aware that the payment for treatment is only an estimate and could change depending on benefit information and information received from the insurance carrier. Insurance carriers have a history of making partial payments lower than both parties expected, or in worst-case scenarios they do not pay at all. This office has no control over these circumstances. These issues remain the sole responsibility of the policy holder. Insurance payments are accepted by our office as partial payments toward your balance. Therefore, we will expect payment from you for the portion of payment your insurance carrier is not responsible for paying, including but not limited to deductibles and co-payments, and non-covered services and analgesia. Once we have filled your insurance claim, we will allow 30 days for your insurance company to reimburse our practice. It is common practice for insurance companies to deny claims. If an insurance claim has not been paid within 30 days, it becomes the subscriber's sole responsibility to pay the balance, regardless of the reason. If we have not collected our full payment within 60 days, the subscriber then becomes responsible for the entire balance. The subscriber will be provided with the appropriate information to handle their claim directly through their insurance company and this office will assist subscribers with obtaining payment to the best of our ability within reasonable limits.

If a bill becomes outstanding in our office, this office is not obligated to render further treatment until the total amount due has been paid in full. Outstanding balances sent to collections are subject to court cost and administrative fees. Patients needing emergency care who have no dental insurance will be required to pay for any needed treatment, including but not limited to exam and radiographs prior to entering the clinical area or prior to treatment being rendered. Patients needing emergency care on weekends or after normal office hours are required to pay for services rendered in cash, regardless of insurance coverage. Occasionally it is necessary to charge a deposit for treatment. If a deposit is paid and then treatment is cancelled or discontinued at the request of the parent or guardian, the deposit may be retained by this office to offset costs that result from the lack of income incurred by this office when our dentists are unable to work for a scheduled period of time. This office utilizes the assistance of a collection service to attempt to collect debts. Should this occur, you will be responsible for collection fees as well as any court costs if necessary. We thank you in advance for your understanding.

Please Initial: _____

Appointment Policy

Our office is dedicated to quality care and exceptional service. In order to continue with such service, we have adopted the following policies:

- This office requires 48 hours notice of cancellation.
- If 48 hours notice is not provided, a service/rescheduling fee of $35.00 per appointment will be added to your account.
- If 48 hours notice is not provided for an operative appointment, a service/rescheduling fee of $55.00 per appointment will be added to your account.
- If patient is more than 10 minutes late for an appointment, we will reschedule the appointment.

This office would also like to inform our patients of the following:

- Reminder phone calls are a courtesy of this office and are not required.
- Patients are fully responsible to remember and keep appointments.
- Patients should not depend on reminder phone calls from this office and are fully responsible for remembering appointments.

There is a $100.00 fee for after-hours emergency dental visits, to be paid at the time of service. Thank you for your cooperation.

We are aware of school policies that make it difficult for children to be out of school for any reason. However, medical and dental appointments are excused absences with a doctor's school note and signature stating that the child was in the office. Although we would like to see all school-age patients after school, this is not possible. Therefore, to make certain everyone has a fair share of after school appointments, the following guidelines have been set. Please help your child and others by not asking for exceptions.

Appointments for school-age children will alternate between school and after school hours. This means you will be asked to bring your child during school hours only once or twice per year. If for any reason you fail to come or cancel for an after school (evening) appointment, the missed appointment will be rescheduled during school time so that we may maintain the pattern of every other appointment after school.

Your cooperation in complying with these guidelines is appreciated. We are concerned with school policies and believe these schedules will best benefit every patient. It is our desire to serve each and every one of you without causing your child to miss extensive school time. We appreciate you choosing our office for your child's dental care.

_____ _____

Signature Date

Bhat & Associates

Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

Doctor Credentials

Geeta Bhat, DDS - General Dentist

- New York University College of Denistry 2000
- Wilkes-Barre Veteran's Hospital General Practice Residency 2001
- York Hospital General Practice Residency 2002

Acknowledgement of credentials, please initial: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have access to your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Printed Name

_____ _____

Signature Date

Office Use Only: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Bhat & Associates
Geeta Bhat, D.D.S. - General Dentist

Bhat & Associates
3 Regional Circle
Pinehurst, NC 28374

Tel 910-215-2583
Fax 910-235-4160

www.GeetaDDS.com

X-ray Information

Please familiarize yourself with the x-ray information below.

Are dental x-rays really necessary?
YES. Many diseases, lesions and conditions can only be detected with the use of dental radiographs. It is impossible to see directly between the teeth or under the gums or bone without the use of a dental radiograph. Many times the patient has no signs or symptoms of disease. Without the use of dental radiographs, the dentist is limited to detect only the disease that is visible in the mouth. Dental x-rays can detect disease much sooner than the clinical examination alone. This enables the dental practitioner to identify problems early so that pain and extensive, costly treatment can be avoided.

How often should I have dental x-rays?
There is no set time interval between x-ray exposures. The radiographic exam should be based on the needs of the individual. For example, people with decay will need x-rays more frequently than people without decay.

Can I refuse x-rays and be treated without them?
NO. Treatment without the necessary radiographs is considered negligence. If a patient refuses to have necessary dental x-rays taken, then the dentist must refuse to provide patient care.

Can the dentist use my x-rays from my previous dentist?
YES. If the x-rays are of good diagnostic quality and are recent enough, then the dentist may use them for the oral radiographic examination. Some additional radiographs may still be necessary depending on the needs of the individual.

How much radiation will I receive from dental x-rays?
We are exposed to radiation every day from various sources such as: airplane travel, high altitudes, radon gases and home appliances.

Source		Estimated Exposure
Dental radiographs	Bitewings (4 films)	0.038
	Full-mouth series (about 19 films)	0.150
Medical Radiographs	Lower GI series	4.060
	Upper GI series	2.440
	Chest	0.080
Average radiation from outer space in Denver, CO (per year)		0.510
Average radiation in the U.S. from natural sources (per year)		3.000

Source: Adapted from Frederiksen, NI. X-rays: What is the Risk? Texas Dental Journal. 1995; 112(2); 68-72. Bibliography Iannucci, JM, Howerton, U:Patient Education and the Dental Radiographer. In Dental Radiography Principles and Techniques, Third Edition, St. Louis, 2006, Saunders, pp. 151-153.

Note: It is our observation that many patients appear to be under the impression that x-rays are a technique that dentists use to enhance profits. This is simply not the case.
During your visit, if x-rays are needed for records and/or to enhance treatment decisions, we will let you know prior to taking the x-rays. However, if your feeling about dental x-rays conflict with what we feel is necessary for the examination, then we will halt treatment and refer you to another provider.

Printed Name

Signature

Date