



Geeta Bhat, D.D.S.
 Serving Apex, Cary & Surrounding Areas

Geeta Bhat, D.D.S.
 3434 Kildaire Farm Rd, Suite 138
 Cary, NC 27518

Tel 919-362-3862
 Fax 919-362-6385

www.GeetaDDS.com

Patient Information

Patient's Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Male Female

Referred by: _____

Mother's Name: _____ Phone #: _____

Address: _____

Employer: _____ Work/Cell #: _____

SSN or Drivers License #: _____

Father's Name: _____ Phone #: _____

Address: _____

Employer: _____ Work/Cell #: _____

SSN or Drivers License #: _____

Nearest Relative: _____ Phone #: _____

Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Suscriber Social Security #: _____ Group #: _____

Carrier Address: _____

Carrier Phone #: _____

Has your child had an exam, cleaning, fluoride treatment or X-ray in the past six months? Yes No

Has your child had restorative work including fillings this year? Yes No

Please list all persons who may schedule appointments, call for medical advice, or bring your child to the office for treatment (i.e. grandparents, babysitter, neighbor). These individuals will be asked to present identification at the time of the visit. If someone other than these persons contacts us about your child, we will contact the parent or guardian 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 your child, 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 child's 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.

 Parent/Guardian Signature

 Date



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Health History

Name of child's physician: _____ Date of last physical exam: _____

Is your child in good health? Yes No

Has your child ever had a health problem? Yes No

If so, please describe: _____

Has your child ever been hospitalized? Yes No

If so, please give reason & dates: _____

Is your child allergic to anything? Yes No

If so, please describe: _____

Is your child currently taking any medications? Yes No

Please give medication, dose & reason: _____

Were there any problems at birth? Yes No

If so, please describe: _____

Please check if your child has been treated for any of the following:

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

Please elaborate on any items checked: _____

Do you consider your child to be: advanced in the learning process progressing normally slow in the learning process

Was your child: breast fed bottle fed At what age was it stopped? _____

Dental History

Has your child ever been to the dentist? Yes No Name of dentist and date: _____

Has your child experienced any unfavorable reaction from previous dental care? Yes No

If so, please explain: _____

Does your child suck a finger, thumb, or pacifier? Yes No

Please check if your child is having problems with any of the following:

- | | | | | |
|-----------------------------------|---------------------------------------|---|--|--------------------------------|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Teeth Sensitivity | <input type="checkbox"/> Other |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Toothache | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Color of teeth | |

Comments: _____

Is your home water supply fluoridated? Yes No

Does your child use a fluoride toothpaste? Yes No

Do you give your child any other form of fluoride? Yes No If so, what? _____

Consent for Dental Treatment

I request and authorize the doctor to examine, clean, and provide dental treatment on my child's 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 child's dental problem. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The doctor will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any changes incurred on this child for dental treatment.

Parent/Guardian Signature _____

Date _____



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Informed Consent For Treatment

Initial Visit: I understand that during my child's 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 child's mouth, teeth, and gums. In most instances, my child's 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 child's 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 and my child in attaining optimum dental health. The office of Geeta Bhat, DDS will discuss with me the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. The office of Geeta Bhat, DDS 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 performed 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 may occur. Therefore, I have been requested to inform the staff of any known allergies my child may have. Some of these sedative medications can cause drowsiness. When these medications are used I would need to make arrangements for myself or another adult family member to remain with my child for the rest of the day.

Medical History: I understand the medical and dental history is necessary to provide my child 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 Dr. Geeta Bhat, the dental associates or designated staff members of any changes in my child's health or medication prior to treatment.

Treatment: Upon such diagnoses, I authorize Dr. Geeta Bhat, the dental associates or designated staff members to perform all recommended treatment mutually agreed upon. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's 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 patient receives in Dr. Geeta Bhat's office.

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 the patient's 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 agree to be responsible for any service rendered on behalf of my dependents. I understand that payment above and beyond the estimated insurance coverage amount is payable at the time treatment is rendered. I authorize payment directly to Dr. Geeta Bhat, DDS, General Dentistry for Children and Teenagers, of any insurance benefits. I authorize release of any information relating to dental insurance claims.

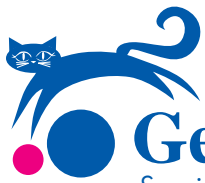
Printed Name _____

Signature _____

Witness Signature _____

Date _____

Date _____



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Financial Policy

The office of Geeta Bhat, DDS is a General Dentistry Practice devoted to the dental care of children and teenagers. 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 your child to this office. Treatment decisions by Dr. Bhat or any other dentist are not made based on your insurance carrier or plan, but rather your child's 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 Dr. Bhat is 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: _____

Missed Appointment Policy

We offer courtesy phone calls a day prior to your visit. Please indicate how you would like us to remind you:

Email: _____ Text Message: _____ Postcard by mail

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 24 hours notice of cancellation.
- If 24 hours notice is not provided, a service/rescheduling fee of \$35.00 per appointment will be added to your account.
- If 24 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.
- Parents are fully responsible to remember and keep appointments.
- Parents 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.

Signature _____

Date _____



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Doctor Credentials

The practice of Geeta Bhat, DDS, PA employs several dentists each with their own unique post-graduate achievements and credentialing. Dr. Geeta Bhat and Dr. Stephen Wiist are general dentists and Dr. Tu is a pediatric specialist. We would like to take this moment to introduce our practitioners to you.

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

Stephen Wiist, DDS - General Dentist

- Ohio State University Dental School 2000
- Wilkes-Barre Veteran's Hospital General Practice Residency 2001

Jenny Tu, DDS - Pediatric Specialist

- Columbia University Dental School 2000
- Columbia Presbyterian Pediatric Residency Program 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.

Patient's Name

Your Name

Relationship to Patient

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



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X-ray Information

Parents: 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 children 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 child. For example, children with decay will need x-rays more frequently than children 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 my child 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 conflicts with what we feel is necessary for the examination of your child, then we will halt treatment and refer you to another provider.

Patient Name

Signature of Parent/Guardian

Date