Serenitydental

JAY M. BHATT DDS

Welcome to our practice, we would like to take this opportunity to let you know how pleased we are that you have chosen our office. It is our privilege to serve you and to provide our best possible care. Thank you again for selecting us. Listed below are some policies of our office to ensure a long lasting patient experience.

RESERVATIONS

Our team values your time as a patient. We ask your help and effort in keeping with the schedule by being prompt to your given reservation time. It is our commitment to extend the same courtesy by seeing our patients on a timely manner. We understand that due to unforeseen circumstances you may have to change your reservation and ask that you would give us 24 hour notice. Repeated cancellations may cause delay in your treatment as well as having to collect in advance your portion of treatment when scheduling. **If your reservation is missed or cancelled the day of your reservation, a $50 charge will be charged to your account. You will be unable to make another reservation until the broken reservation fee of $50 is paid prior to scheduling your next reservation.**

Signature: _____ Date:_____

INSURANCE / COPAY

Dental insurance benefits are a contract between the employer and patient. The extent of coverage varies greatly from company to company and sometimes even within the company. It has nothing to do with the level of service provided by the dentist. As a way of extending courtesy to you, we will be glad to process and bill your primary insurance. However, due to the various insurance plans available we can only estimate your portion. Your quoted portion is collected at each reservation. However, insurance companies cannot guarantee payment until the claim is received and processed. If your insurance pays less than what was estimated, then we will bill you up to 60 days after this notice. Any unpaid balance after this 60 day period will be turned over to collections.

EMERGENCIES

Should you experience a dental emergency during non-office hours, Dr. Bhatt is available by phone and every effort will be made to relieve you of your pain. A visit will be needed the following business day to evaluate and diagnosis treatment if needed.

FINANCIAL RESPONSIBILITY

You agree to pay all finance charges, collection costs, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

By signing below, I have read and understand the policies above and agree to adhere to these policies as stated above by Dr. Jay Bhatt D.D.S.

Responsible Party Name: (print) _____

Signature: _____ Date:_____

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Patient Name: _____ Birth Date: _____

DENTAL HEALTH HISTORY

Name of your former dentist: _____ How long since you were last seen? _____

How important is it for you to keep your teeth? 1 2 3 4 5 6 7 8 9 10 Why? _____

On a scale of 1-10, 10 being the best, where would you rate your smile? _____

On a scale of 1-10, 10 being the best, where would you rate your oral health? _____

Have you experienced any of the following?

Y	N		Y	N	
☐	☐	Bleeding gums?	☐	☐	Sensitivity to hot and cold?
☐	☐	Bad breath or sour taste in your mouth?	☐	☐	Snoring?
☐	☐	Burning sensations in mouth?	☐	☐	Food catching between teeth?
☐	☐	Soreness in jaw or mouth?	☐	☐	Clenching or grinding of teeth?
☐	☐	Is it hard for you to open wide?	☐	☐	Pain/soreness around teeth, ears, eyes, face?
☐	☐	Clicking or popping in jaw?	☐	☐	Stiff neck muscles?
☐	☐	Have you/your parents suffered from gum disease?	☐	☐	Do you or your parents wear dentures/partials?
☐	☐	Did you ever wear braces?	☐	☐	Ever been injured in the mouth or head?
☐	☐	Oral surgery of any kind?	☐	☐	Prolonged bleeding following extractions?
☐	☐	Frequent headaches?			
☐	☐	Is the brightness of your teeth important to you?			
☐	☐	Does having dental treatment make you afraid or nervous? If yes, what specific things bother you?			

_____

If you could change anything about your smile which of the following would you want? *(Please check the box(es)*

- ☐ White
- ☐ Replace missing teeth
- ☐ Remove stains/spots on teeth
- ☐ Less gum showing
- ☐ Close space or spaces
- ☐ Replace old crowns
- ☐ Replace old plastic fillings
- ☐ Reshape/resize my teeth
- ☐ Replace chipped teeth
- ☐ Remove silver fillings
- ☐ Straighter

Which are important to you when making your dental decisions? *(Please check the box(es)*

- ☐ Convenience
- ☐ Finances
- ☐ What insurance covers
- ☐ Fear or Anxiety
- ☐ Appearance
- ☐ Time
- ☐ Health
- ☐ Comfort
- ☐ Relationship with Dental Team
- ☐ Quality of care
- ☐ Detailed treatment explanations
- ☐ Technology
- ☐ Other _____

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PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Preferred Name _____

Check Appropriate Box:

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other _____

Birth Date _____ Social Security # _____ Drivers License # _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Referred By _____ Has any other family member been seen in our office? _____

RESPONSIBLE PARTY - *Check if same as above* ☐

Last Name _____ First Name _____ M.I. _____ Preferred Name _____

Check Appropriate Box:

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other _____

Birth Date _____ Social Security # _____ Drivers License # _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

INSURANCE INFORMATION

Policy Holder _____ Birth Date _____ Social Security # or ID # _____

Employer _____ Insurance Co _____ Group# _____

Do you have additional dental insurance? ☐ Yes ☐ No If yes, then complete the following:

Policy Holder _____ Birth Date _____ Social Security # or ID # _____

Employer _____ Insurance Co _____ Group# _____

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Patient Name: _____ Birth Date: _____

HEALTH HISTORY

	YES	NO
Has there been a change in your health within the last year?	☐	☐
Have you been hospitalized or had a serious illness in the last two years?	☐	☐
If yes, explain? _____		
Are you being treated by a physician now?	☐	☐
If yes, explain? _____		
Physicians name _____ Phone _____		
Date of last medical exam? _____		
Do you smoke or use tobacco products? If yes, how many packs per day?	☐	☐
Are you taking Bisphosphonates (Fosomax, Actonel, Boniva Aredia, Bonefos, Didronel, Zometa)?	☐	☐
Are you now taking any medication (including asprin) or herbal supplements?	☐	☐
If yes, please list _____		
_____		
Are you sensitive or allergic to any medication or anesthetics?	☐	☐
If yes, please list _____		

Do you have any specific dental concerns today?

_____

_____

_____

Do you or have you had:

Yes	No		Yes	No		Yes	No	
☐	☐	Adrenal Disease	☐	☐	Diabetes	☐	☐	Jaundice
☐	☐	A.I.D.S	☐	☐	Drug Addiction	☐	☐	Latex Allergy
☐	☐	Allergies	☐	☐	Emphysema	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Mental Disorders
☐	☐	Angina Pectorus	☐	☐	Eye Disease	☐	☐	Mitral Valve Prolapse
☐	☐	Arteriosclerosis	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Heart Attack	☐	☐	Radiation Treatment
☐	☐	Artificial Heart Valve	☐	☐	Heart Disease	☐	☐	Rheumatic Fever
☐	☐	Artificial Joints	☐	☐	Heart Murmur	☐	☐	Rheumatism
☐	☐	Asthma	☐	☐	Heart Pacemaker	☐	☐	Stroke
☐	☐	Bleeding Disorders	☐	☐	Heart Surgery	☐	☐	Sub-Bacterial Endocarditis
☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Hepatitis A	☐	☐	Transplant
☐	☐	Chemotherapy	☐	☐	Hepatitis B	☐	☐	Tuberculosis
☐	☐	Chronic Cough	☐	☐	Hepatitis C	☐	☐	Tumors
☐	☐	Colitis	☐	☐	H.I.V. Positive	☐	☐	Ulcers
☐	☐	Congenital Heart Disease	☐	☐	High Blood Pressure	☐	☐	Venereal Disease

Do you experience:

☐	☐	Chest Pain	☐	☐	Dizziness	☐	☐	Sinus problems
☐	☐	Swollen Ankles	☐	☐	Ringing in Ears	☐	☐	Excessive bleeding
☐	☐	Shortness of Breath	☐	☐	Blurred Vision	☐	☐	Difficulty Swallowing
☐	☐	Recent Weight Loss	☐	☐	Frequent Urination	☐	☐	Dry Mouth
☐	☐	Bruise Easily	☐	☐	Nausea / Frequent Vomiting	☐	☐	

Do you have or have you had any other diseases, conditions, or medical problems NOT listed on this form? ☐ Yes ☐ No

If yes, please explain: _____

WOMEN ONLY:

	Yes	No		Yes	No		Yes	No
Are you or could you be pregnant?	☐	☐	Taking birth control pills?	☐	☐	Are you nursing?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I unders tand that providing incorrect information can be dangerous to my health. I will inform you of any changes in my health or medication

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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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.

Serenity Dental is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that health/dental information about you and your health is personal. We are committed to protecting health/dental information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Serenity Dental and will tell you about the ways in which we may use and disclose health/dental information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of health/dental information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review. This may include quality assessment, staff training, accreditation, licensing activities, and business planning and development.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information for certain situations, such as preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
- Comply with law. We will share information about you if state or federal law requires it, including with the U.S. Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- Do Research. We can use and share information for health research.
- Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative, or other person responsible for your care of your location, general condition, or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
- Organ and tissue donation requests. We can share information about you to organ procurement organizations.
- Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security).
- Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.
- Reproductive health care information. Federal rules may limit when we may use or disclose protected health information related to lawful reproductive health care for certain non-health-care purposes (such as certain investigations, law enforcement requests, oversight activities, or legal proceedings). When required, we may need to obtain a signed attestation from the requester before making certain disclosures.

When it comes to your health information, you have certain rights under federal and applicable state law:

- Get an electronic or paper copy of your health/dental information. You can ask to see or get a copy of your health information that we maintain in a designated record set. We will provide a copy or a summary, as you request, within 30 days (or we will provide you a written explanation if we need more time as allowed by law). If we maintain your information electronically, you may request an electronic copy. You may also request that we send a copy to a person or organization you choose (your request must be in writing, signed, and clearly identify where to send it). We may charge a reasonable, cost-based fee as allowed by law.
- Ask us to correct your health/dental record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we will tell you why in writing within 60 days.
- Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
- Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no. If you pay for a service or item in full out-of-pocket, you can ask us not to share information about that service or item with your health plan for payment or our operations. We will agree unless a law requires us to share that information.
- Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

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- Substance Use Disorder (SUD) Records (42 CFR Part 2) (if applicable). If we receive or maintain records that are subject to 42 CFR Part 2, those records may have additional federal protections and limitations on use and disclosure. We will follow applicable Part 2 requirements when they apply, including any requirements related to patient consent and restrictions on redisclosure.
- Fundraising**.** We do not use your information for fundraising communications.
- Privacy Notice. You can ask and receive a paper copy of this notice at any time.
- Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Uses and disclosures that require your written authorization: We will not use or disclose your protected health information without your written authorization for the following purposes (except as otherwise permitted by law):

- Marketing.
- Sale of protected health information.
- Most uses and disclosures of psychotherapy notes (if applicable).

You may revoke your authorization in writing at any time unless we have already acted based on it.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer. Some types of information (for example, certain mental health, HIV/AIDS, genetic, or substance use disorder information) may have additional protections under applicable law.

We are required by law to maintain the privacy and security of your protected health information. We will notify you following applicable legal requirements if a breach occurs that may have compromised the privacy or security of your information. This notice is effective as of January 1, 2026. We reserve the right to change this Notice, and the changes will apply to all protected health information we maintain. We will make the updated Notice available upon request, in our office, and on our website (if applicable)

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Alice , by mail at: 3341 East Queen Creek Road Suite 101 Gilbert AZ. 85298 or telephone at 480-457-8877. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I request that information not be discussed with family or friends except as permitted by law (for example, in emergencies).
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____

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Patients Only In Operatory Rooms

For Parents:

We find that children do best by themselves with our experienced dental team. Children behave better when they have one-on-one time with the team. It's our time to establish rapport with your child and find out if he/she is comfortable/mature enough to be in a family dental practice or be better served at a Pedodontist. The operatories are completely open and your child will be under the supervision of a team member at all times. You are more than welcome to check on your child periodically but we ask that you do not go into the operatory. Our goal is to provide the best experience for your child while protecting the privacy of our other patients under HIPPA guidelines.

_____ Date_____

For Patients:

For all patients, we only allow those who are receiving treatment back in the operatories. We would like to honor all of our patients' privacy. Please have your family wait for you in the front lobby until we have finished with your treatment.

For parents with children. We ask that you make accommodations for your children. Children are not allowed in the operatory when parents are having their treatment for their safety and the patient's safety. Children can be curious and can hurt themselves from our instruments, treatment chairs etc.

By adhering to these requests, we can provide the best, most efficient, comfortable and safe quality care for our patients. Thank you.

_____Date _____