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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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have 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)

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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 _____