BHARATHI GORTHI DDS INC

PATIENT INFORMATION

Name: **Last**_____**First**_____Middle_____ **SS/HIC/Patient ID**: _____
Sex ( ) M ( ) F Age: _____ **Birthdate:** _____ ( ) Married ( ) Widowed ( ) Single ( ) Minor
( ) Separated ( ) Divorced ( ) Partnered for _____ yrs
Address: _____ City: _____ State: _____ Zip Code _____
Phone (Home): (____) _____ Cell Phone: (____) _____ Best time/day to call: _____
Preferred Appointment Times: ▫ Morning ▫ Afternoon ▫ Evening ▫ Any Time ▫S ▫M ▫T ▫W ▫T ▫F ▫S
Patient Employer/School: _____ Occupation: _____
Employer/School Address: _____Employer/School Phone: _____
City: _____ State: _____ Zip Code_____
In case of emergency who should be notified: _____ Phone: _____
How did you hear about us?
Yelp: _____ Church: _____
Manila Mail: _____
Family or Friends: _____ Others: _____
Email:_____

PRIMARY INSURANCE

Person Responsible for Account: _____
Relationship to Patient: _____ **Birthdate**: _____ **Soc. Security** # _____
Address (if different from patient) _____ State: _____ Zip Code _____
City: _____ Occupation: _____
Business Address: _____ Business Phone: (_____) _____
Insurance Company: _____ Social Security # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ( ) Yes ( ) No
Subscriber Name: _____ Birthdate: _____ Phone: (_____) _____
City: _____ State: _____ Zip Code _____
Subscriber Employed By: _____ Business Phone (____)_____
Insurance Company: _____ Social Security # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____-

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility the part of each patient must be determined before treatment. I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____
Signature of Patient/Parent/Guardian or Personal Representative Date

_____ _____
Please print name of Patient/Parent/Guardian or Personal Representative Date

DENTAL HEALTH HISTORY

(Confidential)

DENTAL HISTORY

Patient Name:_____

Reason for Today's Visit: _____

Former Dentist: _____

Address: _____City: _____State: _____ Zip Code _____

Date of Last Dental Care: _____ Date of Last Dental X-Rays: _____

Check if you have/had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Filling
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____

Have you had any serious illness or operations: _____

Have you ever had any blood transfusion: _____

(WOMEN) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or had any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	Cortisone Treatments	☐	☐	Hemophilia	☐	☐	Respiratory Disease
☐	☐	Anemia	☐	☐	Cough Up Blood	☐	☐	Hepatitis A or B	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Arthritis, Rheumatism	☐	☐	Skin Rash	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	HIV Pressure	☐	☐	Stroke
☐	☐	Fainting	☐	☐	Back Problems	☐	☐	Jaw Pain	☐	☐	Swelling of Feet/Ankle
☐	☐	Glaucoma	☐	☐	Blood Disease	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Liver Disease	☐	☐	Tonsillitis
☐	☐	Tuberculosis	☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Nervous Problems
☐	☐	Ulcer	☐	☐	Psychiatric Care	☐	☐	Heart Problem	☐	☐	Chemotherapy
☐	☐	Circulatory Problem			Describe _____						
☐	☐	Other _____									

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Other _____

MEDICAL HISTORY UPDATE

Date: _____ **Date:** _____ **Date:** _____ **Date:** _____

Signature:_____ **Signature:** _____ **Signature:** _____**Signature:** _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors of omissions that I may have in the completion of this form.

Signature: _____ **Date:** _____

BHARATHI GORTHI DDS INC

665 South Knickerbocker Dr #9 Sunnyvale, CA 95081
Phone: 408.634.3368 Fax: 408.739.2928

INFORMED CONSENT FORM

NAME: _____

I. TREATMENT TO BE DONE

I understand that I am having the following work done ( ) Fillings ( ) Bridge ( ) Crown ( ) Extractions

( ) Impacted Teeth Removed ( ) Sedation ( ) Root Canals ( )Other _____

II. DRUGS, MEDICATIONS, AND SEDATION

I have been informed and understand that antibiotics, analgesic and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) and they can cause pain, thrombophlebitis (inflammation of a vein from intravenous and intramuscular injections). Injury to and stiffening of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agreement not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to make medications prescribed for me in the manner prescribed may offer risk of continued infection and pain and potential resistance to effective treatment of my conditions.

Initials _____

III. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were have not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to my Dentist to make any or all changes and additions necessary.

Initials _____

IV. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph III. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, numbness in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arises during or following treatment, the costs of which is my responsibility.

Initials _____

V. CROWNS, BRIDGES, INLAYS, ONLAYS, AND VENEERS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

Initials _____

VI. FILLINGS

I have been advised for the need of fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I maye need to receive more extensive treatment (such as rooth canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

Initials _____

VII. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)

I realize there is no guarantee that root canal treatment will save the tooth, and the complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessary affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Initials _____

VIII. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have serious condition, causing and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment may have and have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials _____

I understand that Dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance have been made by anyone regarding the dental treatment which I have the requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for dental care of me. I also understand that no other than the treating Dentist is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative and have been given an appointment date to return.

Signature:_____ Date: _____

Doctor:_____ Date: _____

BHARATHI GORTHI DDS INC
ARBITRATION AGREEMENT

Article I

It is understood that any dispute as to dental malpractice, That is, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article II

A. *Parties to the Agreement.* The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, Children (whether born or unborn), and heirs, assigns, or personal Representatives. The individual signing this Agreement signs it on Behalf of the foregoing persons, and intends to bind each of them to Arbitration to the full extent permitted by law.

The term "Doctor" as used in this Agreement includes the undersigned doctor and his or her professional corporation or Partnership, and any employees, agents, successors-in-interest, Heirs, and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, intends to bind each of them to arbitration to the full extent permitted by law.

B. *Treatment Covered.* Patients understands and agrees that any Dispute of the sort described in Article I between Doctor and Patient will be subjected to compulsory, binding arbitration.

C. *Other Doctors (If Applicable).* Patient understands that he or she may at any times receive treatment form one or more doctors who practice jointly with the undersigned doctor. It is understood and agreed that any dispute of the sort described in Article I between Patient and such Doctors practicing with the undersigned doctor will be subject to compulsory, binding arbitration.

D. *Coverage of Prenatal Claims (If Applicable).* Patient understands and agrees that, if Doctor treats her during pregnancy, and dispute of the sort described in Article I as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III

A. *Informal Resolution of Dispute.* In the event of Patient feels that the problem has arisen in connection with the medical care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

B. *Method of Initiating Arbitration.* If the dispute is not resolved by mutual agreement within 90 days. Patient may initiate arbitration by notifying Doctor to the effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that more than two parties participate, parties aligned with patient shall select one arbitrator, and parties aligned with Doctor shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

C. *Applicable Law.* The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1290-1296). The arbitrators shall, in addition, have authority to the order such other discover as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the Medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.

D. *Interpretation of Agreement.* Any controversy concerning the interpretation or application of this Agreement itself shall also be submitted to arbitration in the manner provided above.

Article IV

Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from dental services rendered prior to the revocation shall be subject to arbitration.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME (PLEASE PRINT): _____

DATE: _____ SIGNED: _____

DATE: _____ DOCTOR: _____

HIPAA PRIVACY RULE RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

BHARATHI GORTHI DDS INC

665 South Knickerbocker Dr #9 Sunnyvale, CA 95081
Phone: 408.634.3368 Fax: 408.739.2928

I understand that, under the Health Insurance Portability & Accountability Act 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 the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 at the address above 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 healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide such restrictions.

PATIENT NAME: _____

RELATIONSHIP TO THE PATIENT: _____

SIGNATURE: _____

DATE: _____

Offices Use Only

I attempted to obtain the patient's signature in acknowledgement on this *NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT*, but was unable to do so as documented below.

DATE	INITIALS	REASONS