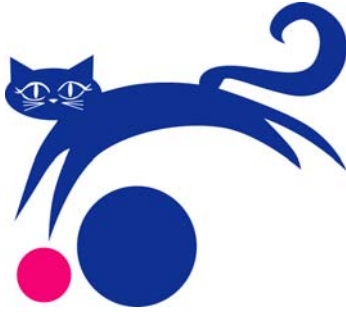


General dentistry for children and teenagers
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INFORMED CONSENT FOR TREATMENT

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 YOUR CHILD'S DENTAL PROBLEMS AND YOUR CONCERNS AND DESIRES FOR TREATMENT (3) X-RAYS (4) EXAMINATION OF THE MOUTH AND SUPPORTING STRUCTURES (5) CONFERENCE WITH PREVIOUS OR 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 D.D.S. WILL DISCUSS WITH ME THE MOST APPROPRIATE AND IDEAL TREATMENT PLAN AS WELL AS REASONABLE ALTERNATIVE TREATMENT PLANS. THE OFFICE OF GEETA BHAT D.D.S WILL ALSO INFORM ME OF THE LIKELY DENTAL PROGNOSIS 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 ANESTHETIC (COMMONLY REFERRED TO AS NOVOCAINE 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 REMAINDER OF THE DAY.

MEDICAL HISTORY: I UNDERSTAND THE MEDICAL AND DENTAL HISTORY ARE 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. BHAT OF ANY CHANGES IN MY CHILD'S HEALTH OR MEDICATION PRIOR TO TREATMENT.

TREATMENT: UPON SUCH DIAGNOSIS, I AUTHORIZE DR. GEETA BHAT OR THE DESIGNATED STAFF MEMBER 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 THE 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, AND THE BENEFITS TO BE REASONABLY EXPECTED FROM THIS TREATMENT PLAN, COMPARED TO ALTERNATIVE APPROACHES AND/OR NO TREATMENT. I UNDERSTAND THAT DURING, 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 GEETA BHAT D.D.S GENERAL DENTISTRY FOR CHILDREN AND TEENAGERS OF ANY INSURANCE BENEFITS. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO DENTAL INSURANCE CLAIMS.

PRINTED NAME

SIGNATURE

DATE

WITNESS SIGNATURE

DATE