DR. GARY J. WESTERMAN, DMD
1063 Main Street North • Southbury, CT 06488
(203) 264-5630

Welcome to our office!

OUR FINANCIAL MENU

FORMS OF PAYMENT:
To facilitate what we believe is your right to the best dental care available, you may choose from any of the following (including any combination thereof): cash, personal check, Mastercard, Visa, or extended payments with our health care card (ask for details). Balances over 60 days may incur a finance charge of 18% APR.

REGARDING PRIVATE INSURANCE PLANS:
Your insurance is a method for you to receive reimbursement for a percentage of your dental treatment. The range of benefits for a given procedure may be from 0-100%, depending solely on what your employer wishes to offer his/her employees. In addition, some plans base their mount of benefit on a schedule of fees arbitrarily determined by the insurance companies. For a given procedure, therefore, you may receive a lower percentage of our actual fee than the reimbursement level indicated in your dental plan.

We will be happy to assist you in completing and submitting your claim forms. We ask for all estimated co-payments at the time of treatment.

The financial obligation for dental treatment is between you and our office; the insurance company is responsible to you, and not to our office. Once your carrier has paid the claim, any difference will be due upon receipt of the statement. If for any reason we have not received your insurance carrier's payment within 90 days after the claim, the remaining balance will be due and payable by you at once and subject to 18% APR.

APPOINTMENTS:
Appointment Times are reserved especially for you. Kindly give at least 24 hours notice if changes must be made. There may be a fee charged if an appointment is missed without proper notice.

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all information which is necessary to process my insurance claims and pertinent to my dental care. I assign all dental benefits to which I am entitled to Dr. Westerman. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as value as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient_____**Date**_____

(Parent/Guardian if minor)

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. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your legal rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of his Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use for your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those describe in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only of you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate of patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will chart you $_____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed a the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at the alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Contact Officer: Donna Cichowski

Telephone: **(203) 264-5630** Fax: **(203) 264-7873**

E-mail: _____

Address: **1063 Main Street North, Southbury, CT 06488**

Gary J. Westerman, DMD

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

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.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify):

_____

_____

_____

GARY J. WESTERMAN, DMD

I understand that my appointment times have been reserved specifically for me. If I must cancel or change my appointment, I will give at least 24 hours notice. I further understand that if I miss any appointments without giving 24 hours notice, or arrive excessively late, additional appointments will not be given.

Patient X _____ **Date** _____
(Parent/Guardian if minor)

Gary J. Westerman, D.M.D.
1063 Main St., North, Southbury, CT 06488
Tel: 264-5630

Medical History

Today's Date _____

Name _____ Marital Status: Single___ Married___ Name of Spouse _____
Last First MI

Address _____ City_____State_____Zip Code_____

Home Phone_____ Bus:_____ Cell:_____ Email: _____

Date of Birth_____Sex_____Height_____Soc. Sec. #_____Occupation _____

Physician's Name and Telephone No. _____

How did you hear about our office? _____

Chief dental problem _____

Other dental concerns? _____

If child, name of parent or legal guardian _____

Do you have dental insurance?_____Name, Policy # (if known) _____

PLEASE ANSWER ALL QUESTIONS BELOW

In the following questions, circle yes or no, whichever applies.
Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. Date of last physical examination _____
4. Have you had any serious illnesses or operations? ..... Yes No
   If yes, describe _____
5. Do you smoke, or former smoker? (circle) ..... # packs/day? _____ Yes No
6. Heart Problems
   a. Artificial heart valve, (describe) ..... Yes No
   b. History of subacute bacterial endocarditis ..... Yes No
   c. Heart attack (Date) _____ Yes No
   d. Congenital heart lesions ..... Yes No
   e. Cardiovascular disease *(circle):* heart failure, angina, arteriosclerosis, arhythmia ..... Yes No
   f. Pacemaker or implantable defibrillator (describe) ..... Yes No
7. Artificial joint (hip or knee) ..... Date of placement ..... Yes No
8. High blood pressure ..... Yes No
9. Stroke or transient ischemic attack (TIA) (describe) ..... Yes No
10. Asthma ..... What causes your asthma? _____ Carry inhaler? _____ Yes No
11. Chronic respiratory problems *(specify)* _____ Yes No
12. Fainting spells or seizures (circle) ..... What brings these on? _____ Yes No
13. Diabetes – (self or immediate family member) (circle) ..... Yes No
14. AIDS, HIV, or other immune suppressive disorders ..... Yes No
15. Hepatitis, jaundice, or liver disease ..... Yes No
16. Tuberculosis ..... Yes No
17. Have you noticed any of the following:
    Night sweats, bloody sputum, sudden weight loss, or productive, prolonged cough for over 3 weeks duration? ..... Yes No

18. Rheumatoid arthritis or lupus ..... Yes No
19. Kidney disease ..... Yes No
20. Venereal disease ..... Yes No
21. Cancer *(specify)* _____ Yes No
22. Thyroid problems ..... Yes No
23. Abnormal bleeding or blood disorders ..... Yes No
*24. Are you taking any drugs or medications? Including herbal ..... Yes No
If so, what? _____
*25. Allergies (drugs, anesthetics, foods, etc.) Describe your allergic reaction ..... Yes No
Please list _____
26. Are you pregnant? ..... Yes No
27. Other _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient or legal guardian Signature of Dentist

Gary J. Westerman, D.M.D.

1063 Main St. North, Southbury, CT 06488

DENTAL QUESTIONNAIRE

	YES	NO
Have you been satisified with prior dental experiences?	___	___
Describe_____		
Do you like your smile?	___	___
Do you ever hide your smile?	___	___
What would you change if you could with respect to the color, shape, and/or straightness of your teeth?_____		
What is most important to you about your teeth/mouth?_____		
Do your gums ever bleed when you brush, floss, or at other times?	___	___
Do you feel that you have enough teeth to chew with?	___	___
If you have a removable partial or full denture, how is the fit and comfort?_____		
Does it stay in well?	___	___
Do you ever have any discomfort in your teeth, gums, or jaw?	___	___
Explain_____		
Are you aware of grinding or clenching your teeth?	___	___
Are your teeth or muscles in your face sore when you wake up?	___	___
When you chew, do you notice pain, popping, or clicking in your jaw?	___	___
Do you have frequent headaches or neckaches?	___	___
Can you comfortably eat anything that you want?	___	___
Do you or anyone in your family snore?	___	___
Have you ever been told that you stop breathing or gasp in your sleep?	___	___
Do you frequently feel tired or fatigued during the day?	___	___

Patient Name_____ Date_____