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)

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, arrhythmia	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		

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 Street North
Southbury, CT 06488
Tel: 264-5630

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_____