Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Date______________

Name________________________________ Birthdate______________ Social Security #______________

Address________________________________ City______________ State________ Zip________

Home Phone #______________ Cell Phone #______________ Referred By______________

Patient's or Parent's Employer________________________________ Work Phone______________

Business Address ________________________ City______________ State________ Zip________

Spouse or Parent's Name ______________________ Employer______________ Work Phone______________

Check appropriate box: Single ☐ Married ☐ Minor ☐ Email address ______________________

Preferred way to be contacted: Home # ☐ Cell # ☐ e-mail ☐ Work # ☐

Person to Contact in Case of Emergency________________________________ Phone ______________

INSURANCE INFORMATION

Name of Insured________________________________ Relation to Patient______________

Birthdate______________ Social Security #______________ Date Employed ______________

Employer ______________________ Insurance ID #______________ Work Phone______________

Employer Address________________________ City______________ State________ Zip________

Insurance Company______________________ Group #______________ Union or Local #______________

Address________________________________ City______________ State________ Zip________

RESPONSIBLE PARTY (If Different From Insured)

Name of Person Responsible for this Account ________________________ Relation to Patient ______________

Address________________________________ Home Phone ______________

Social Security # ______________________ Birthdate______________ Work Phone______________

Employer ____

Currently a Patient in our Office? ☐ Yes ☐ No

ADDITIONAL INSURANCE

Name of Insured________________________________ Relation to Patient______________

Birthdate______________ Social Security #______________ Date Employed ______________

Employer ________________________________ Work Phone______________

Employer Address________________________ City______________ State________ Zip________

Insurance Company______________________ Group #______________ Union or Local #______________

Address________________________________ City______________ State________ Zip________

OVER

Dental History

Reason for Today's Visit ______________________________

Former Dentist ______________________________

Address ______________________________

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 fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________ How often do you brush? ______________

Medical History

Physician's Name ______________________________ Date of Last Visit ______________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________

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

Check (√) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

  Describe ______________
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Sickle Cell
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Comments:

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MEDICATIONS

List medications you are currently taking:

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☐ Not taking any at this time

ALLERGIES

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☐ None

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ______________

Payment is due in full at time of treatment unless prior arrangements have been approved.

Westmeyer Dental
Andrew P Westmeyer
Financial Policy Agreement

Thank you for choosing Westmeyer Dental for your dental care. We are committed to providing excellence in care and treatment. Please understand that your financial responsibility is part of your treatment.

- All patients must complete our patient information, health and insurance forms prior to treatment. (If we have mailed the forms to you, please return them to the office prior to your appointment.)
- Please have your dental insurance card available at your appointment.

Regarding Insurance

- Any deductibles and co-payments are to be paid at the time of service.
- If there is a balance to your account after insurance payment has been received, it will be due and payable within 30 days.
- Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Therefore we can only estimate your copayment. It is by no means a guarantee of payment.

Patients Without Insurance or Non-Covered Procedures

- Patients are responsible for full payment at the time of consultation and/or treatment.
- For charges over $300.00, we offer a 5% courtesy if paid in full by check or cash only at time of treatment.

Payment Options

- We accept cash, check or money order.
- We accept MasterCard, Visa, Discover and American Express

Cancellation of Appointments

- Please give a 24-hour advance notice so we can schedule another patient in that allotted time

Interest

- We reserve the right to charge interest in the amount of 1% as provided by state law 30 days after the last insurance payment.

Returned Checks

- There will be a $35.00 returned check fee assessed to your account. Please contact our office immediately for resolution.

Accident Cases

- We do not accept letters of protection from attorneys. Payment for services will be due at the time of treatment. We will provide you with forms for you to be reimbursed directly by your insurance carrier.

Signature

I have had full opportunity to read and consider the contents and agree to your Financial Policy Agreement.

______________________________ Signature

________________________ Date

If a personal representative on behalf of the patient signs this, complete the following:

Personal representative's name: ______________________________

Relationship to patient: ____________________

Westmeyer Dental, Inc.

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 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 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this 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 crested or received before we made the changes. Before we make a 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 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 providers 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, conducing training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of 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 which it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described 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 if 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 heath information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 your health or safety or the health or 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 authorize 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 or patient under certain circumstances.

Appointment Reminders: We may 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 photo copies. 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 end of this Notice. We will charge you a reasonable cost=based fee for expenses such as copies, we will charge you $5.00 for each page, $20.00 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 at 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, 20013. 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.

Restriction: You have the right to request that we place addition 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 she 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 practice 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 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ashley Krieghoff
Telephone: 419-382-3485 Fax: 419-382-3559.
E-mail: info@westmeyerdental.com
Address: 4560 Heatherdowns Blvd., Ste. 200
Toledo, OH 43614

Westmeyer Dental, Inc

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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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