



**JAY B. WETTSTEIN**  
GENERAL & COSMETIC DENTISTRY

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Male  Female Last First MI

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

Other Family Members Who are Currently Patients: \_\_\_\_\_

In Case of Emergency

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

Hay Fever  
 Allergies

Growths  
 Pacemaker  
 Head Injuries  
 Heart Disease  
 Heart Murmur  
 Hepatitis  
 High Blood Pressure  
 Sinus Problems  
 Kidney Disease  
 Liver Disease  
 Mental Disorders  
 Osteoporosis Trmt  
 Pregnancy  
Due date: \_\_\_\_\_

Radiation Treatment  
 Respiratory Problems  
 Rheumatic Fever  
 Stroke  
 Tuberculosis  
 AIDS/HIV  
OTHER:  
 \_\_\_\_\_

**Are you now taking or have ever taken:**

Bone density medications (Fosamax, Aredia, Zometa, Actonel)  
 Diets Pills  
 Blood Thinners (Coumadin, Plavix, or Aspirin)

Codeine Allergy  
 Penicillin Allergy  
 Artificial Joints  
 Asthma  
 Blood Disease  
 Cancer  
 Diabetes  
 Dizziness  
 Epilepsy  
 Excessive Bleeding  
 Glaucoma

**Current Medications:**

• Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

**Referral Information**

**Whom may we thank for referring you to our practice?**  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_



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## Patient Consent Form

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The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment ,or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records: We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain consent. We also reserve the right to disclose treatment information to family members on your Family File in order to bill household units with one statement.

You may refuse to consent to the use of disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may change your requests or restrictions. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

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**Print Name**

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**Signature**

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**Date**



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**Primary Spouse or Responsible Party Information**

Name: \_\_\_\_\_  
Last First MI

Male  Female  Married  Single  Child  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plane Name and Address: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Secondary Responsible Party**

Name: \_\_\_\_\_  
Last First MI

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plane Name and Address: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**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 on the part of each patient must be determined before treatment. **All appointments cancelled without 24 hours notice will be subject to a service charge.**

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient