Dr. Mark Jerman and Dr. Jennifer Rekos

# Welcome and thank you for choosing Jerman Family Dentistry

We provide dental services for the entire family. The following is helpful information to serve you better as a patient. If there are questions you have which are not answered below, don't hesitate to contact our office at (614) 885-5158.

**Our Office Hours:**

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| Monday, Tuesday, Thursday | 8:00am - 5:00pm |
| Wednesday | 7:00am - 1:00pm |
| Friday | 7:00am - 12:00pm |

The office will be closed for lunch from 12:00 - 1:00 daily except on Wednesday.

We see emergency patients daily. Please call our office as soon as possible so that we can find an emergency appointment for you. If your emergency is during non-patient hours, please use the number given on our voicemail. Your call will be returned as soon as possible.

We accept many types of dental insurance, however we are not providers for Medicaid, Medicare or Worker's Comp. Please have your specific information ready in advance of your appointment so that we can be prepared to discuss your financial responsibility.

Jerman Family Dentistry will be happy to submit your dental insurance claims for you. We will do our best to estimate out of pocket expenses in advance. Please be prepared to pay your patient portion at the time of service. For your convenience, we accept cash, checks, credit cards or third party financing as payment options.

We send statements 30 days after your dental treatment has been completed. A $3.00 rebilling charge will be added to cover administrative costs, if the balance is not paid in full either by yourself or your dental insurance.

Thank you for the opportunity to care for your dental health.

# Medical History

Patient name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Have you been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____

Medications you are now taking: _____

Are you on a special diet? ☐Yes ☐No Do you use tobacco? ☐Yes ☐No Do you use controlled substances? ☐Yes ☐No

Women: ☐ Pregnant/Trying to get pregnant ☐Nursing ☐Oral contraceptives

Do you take, or have you taken, Phen-Fen, Redux? ☐Yes ☐No

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you allergic to any of the following: ☐Aspirin ☐ Penicillin ☐ Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Sulfa Drugs ☐Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easy
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐ No If yes, _____

Date of last dental cleaning: _____ Last x-rays: _____ Previous Dentist: _____

How often do you brush your teeth? _____ Do you use floss? ☐Yes ☐ No

Lumps or sores in your mouth now? ☐Yes ☐No Do your gums bleed when you brush? ☐Yes ☐No

Any trouble with previous dental treatment? ☐Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of patient, parent or guardian Date

# New Patient Registration Form

Date _____

Patient First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security: _____

Sex: ◯ M ◯ F Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Email: _____

How do you prefer to communicate? ◯ email ◯ text message ◯ home phone

How did you hear about us? _____

Responsible Party If Different Than Patient

First Name: _____ Last Name: _____ MI: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Relationship to Patient: _____

Primary Insurance Information

Name of Insured: _____ SS#: _____

Birth Date: _____ Relationship to Patient: _____

Employer: _____ Address: _____

Insurance Co: _____ Group #: _____ Member ID#: _____

Claims Address: _____

Do you have secondary dental insurance? ◯ Yes ◯ No

Dr. Mark Jerman and Dr. Jennifer Rekos

# Acknowledgement of Receipt of 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 you health information is important to us.

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**Our Legal Duty**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe 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 this notice at any time, provided such applicable law permits the changes. 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 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.

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**Uses and Disclosures of Health Information**

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

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment for you.

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

**Health Care 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 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 uses 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 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 heath care or with payment for your health care, 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 or 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 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. **continued on reverse >**

**Required By Law:** 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 to the health and safety of others.
**National Security:** We may disclose to the 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 or 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).

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**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 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 charge you $0 for each page, $0 per hour for staff time to locate and copy your health information and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your heath 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 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, 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.
**Restriction**: 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 the request in writing.) Your request must specify the alternative means or location, and provide a 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 we should amend the information.) 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.

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**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 alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

**Contact information:**
Mark Jerman DDS
Phone: (614) 885-5158
Fax: (614) 985-1740
Email: info@jermanfamilydentistry.com
510 High Street, Suite A
Worthington, OH 43085

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# Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement.)

I, _____ , have received a copy of Jerman Family Dentistry's Notice of Privacy Practices.

_____
Please print your name

_____
Signature

_____
Date

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**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 document
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)