PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

PT NO SHOWS
N2O PT
FULL ORTHO PT

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

DR ANGELINA ANISIMOVA

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?		If yes	
Do you use controlled substances?	Yes No	If yes	

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

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:

X_____ Date:_____

Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

SPECIAL NOTE TO PATIENTS

A professional cleaning performed by a dental hygienist or a dentist is a medical procedure and must be prescribed by a qualified health care practitioner. In some cases, dental conditions exist that have to be addressed before the cleaning is possible. In other cases, a different type of cleaning than what is usually prescribed is needed for the health of the patient.

Because of this, legally and ethically, an examination and x-rays as required by the dentist must be done before any type of cleaning can be started. After an exam and x-rays have been done, the doctor will be able to see whether or not a cleaning is needed as the next step, or if a different procedure (which may include a more involved type of cleaning is required.

Dr. Anisimova and her staff are committed to helping their patients achieve and maintain healthy teeth and gums for the long term. The procedures we follow are in best interest of achieving this for as many of our patients as possible.

I have read the above statement; I have been given the opportunity to ask any questions about it and I understand it.

PATIENT NAME _____ Date _____

Signature _____ (If patient is a minor Parent or Legal Guardian)

14399 MANCHESTER ROAD
MANCHESTER, MO 63011
TELEPHONE (636) 227-2777
FAX (636) 227-1027

Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

PATIENT APPOINTMENT POLICY

Dear Valued Patient,

Our purpose is to help our patients keep their teeth and gums healthy for life. Proper scheduling of appointments is vital to that endeavor. Therefore, we ask for your cooperation regarding the following appointment policy.

1. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. This means no other patient has been scheduled for that particular patient slot, and that anyone else wishing to schedule for that time has had to be given a different time for their appointment. **We reserve the right to charge for office visit cancelled or broken without 2 business days advance notice (e.g. if your appointment is scheduled for Monday at 3 P.M., and you need to re-schedule, you must call us the prior Thursday at 3 P.M.).** Exceptions to this policy can be determined only on an individual basis according to the circumstances. The broken appointment charge will depend on the procedure and the time reserved. These charges are allowed by your insurance company but considered as the patient's responsibility to pay.
2. In order to insure that we keep to our schedule, and yours, as much as possible and to minimize patient waiting time, it is necessary to schedule certain procedures for specific times during the day. This allows us to provide you with the excellence in care that you expect and deserve. We know that your time is valuable and that none of our patients want to spend any longer in the dentist's office than they have to. Scheduling specified procedures for specific time slots allow us to be more efficient with your treatment and actually minimizes the time you have to spend our office.

If you have any questions about the policy, do not hesitate to ask our office staff. We believe that good communication is the key to excellence in dental care.

Patient Name _____ Date _____

Patient Signature_____(If Patient is a minor Parent or Legal Guardian)

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Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records.

Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individuals relating to my medical or payment information:

Patient Name _____ Date _____

Signature _____ (If Patient is a minor Parent or Legal Guardian)

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Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(s) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name _____ **Date**_____

Signature _____ **(If Patient is a minor Parent or Legal Guardian)**

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Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

PATIENT FINANCIAL POLICY

Dear Valued Patient,

We very much appreciate the trust you have placed in us as your dental provider. Our top priority is to help you achieve healthy gums and strong, healthy teeth that last a lifetime. In order to accomplish this, we have found it necessary to implement certain office policies.

We do require that procedures are paid for in advance of treatment.

In the case where you do have insurance coverage, we will file insurance for the portion of the fee that we estimate they will cover, and you will be required to pay the estimated balance due in advance. Once payment from insurance has been received, if there is any balance still remaining, it will be billed to you. If the payment from the insurance results in a credit balance, this will be refunded to you.

Following is our policy on payment options, should treatment be necessary:

1. Pay in full in advance. Since it requires less administration on our part, should you choose this option we will extend a 5% accounting discount . Also we want to let you know we offer discount to our senior patients

2. Financing. There is a company we work with that provide financing to patients specifically for their dental treatment. This allows you to spread out the cost of your treatment over time, with no interest or low interest charges, depending on which option you choose. This allows you to proceed with your treatment in a timely manner while making low monthly payments.

a. Care Credit, Up to 12 months interest free Extended plans available up to 60 months.

3. "Pay as you go". In the event that you are unable to pay in advance using option 1 or 2 above, you may pay 30 % advance deposit to reserve your appointment(s). The balance remaining is due when you arrive for your treatment.

We will provide you with a copy of any and all financial arrangements we make with you so that you can refer to them in the future.

We strive to ensure you are informed of all of our policies and procedures, and to make all aspects of your experience with us comfortable for you as possible. If you have any questions about this or any other of our office policies, please ask to speak with our Office Manager, so that these can be addressed.

Yours in good health,
Dr. Anisimova and Staff

I have read and I understand the above Patient Payment Policy, and I have been provided with the answers to any questions I have at this time.

Patient Name _____ Date _____

Patient Signature _____ (If a patient is a minor Parent or Legal Guardian)

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Patient Name _____ Date _____

Signature _____ (If Patient is a minor Parent or Legal Guardian)

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