TIME 04:38 PM

DATE 4/30/2019

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:

Time 4:49 PM

DR ANGELINA ANISIMOVA

Date 4/30/2019

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 that you may be taking, c

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		
Do you use controlled substances?	Yes No	If yes	

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 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 above? 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

GENERAL CONSENT FORM

Please read this form carefully. Should you have any questions, our office manager will be delighted to help you.

1. I hereby authorize and direct Dr. Angelina Anisimova and dental auxiliaries/dental hygienist to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand that certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants) other than the dentist.
3. I also authorize Dr Anisimova and dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials and treatment records of my face, jaws and teeth, before, during and after treatment for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records, marketing materials (including website and printed materials) and if in the judgment of Dr. Anisimova, dental research, education, or science will be benefited by their use. Such photographs, diagnostic and treatment information may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research. It is specifically understood that in any such publication or use no patient will be identified by name and full face will not be used (Identifying information will be kept confidential). The aforementioned photographs may be modified or retouched in any way that my dentist, in her discretion, may consider desirable.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of Dr. Anisimova but copies are available upon request. I also understand I do not expect compensation, financial or otherwise, for the use of photographs.
5. In general terms, the dental procedure(s) can include but not be limited to:
   a. Comprehensive oral examination radiographs, cleaning of the teeth, and the application of topical fluoride.
   b. Periodontal treatment including placement of Arestin if it is needed.
   c. Treatment of disease, or injured teeth with dental restorations (fillings), crowns, or root canal treatments.
   d. Oral Surgery: Extraction of one or more teeth.
   e. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
   f. Treatment of Disease or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
6. I understand the Dr. Anisimova is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize the guarantees of results or absolute satisfaction is not always possible in dental health service.
8. I have answered all the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told Dr. Anisimova or other staff member about all medical conditions, including allergies, I also understand if I or my dependent ever had any changes in health status or any change in medications(s), I will inform Dr. Anisimova at the next appointment
9. I authorize Dr. Anisimova' s office to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient name _____

Signature _____ **Date** _____

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

Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

PATIENT APPOINTMENT AND FINANCIAL POLICIES

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:

FINANCIAL POLICY

-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. 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 an accounting discount. Also we want to let you know we offer discount to our senior patients and patients without dental insurance, our office manager will explain you about it.

2. Financing. There is a company we work with, **CareCredit** 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 (6 or 12 months) or extended plans with low interest charges, depending on which option you choose.

3. "Pay as you go". In the event that you want to pay on every visit we accept cash, check or credit cards we will unable to offer any discount on this option. The payment is due when you arrive for your treatment and service is rendered.

APPOINTMENT POLICY

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/email (one week in advance and 2 days before) 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 schedule 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 a minimum fee of $35 for any appointment cancelled or missed without a 2 (two) business day advance notice** (e.g. if your appointment is schedule for Monday at 3 pm and you need to re-schedule, you must call us the prior Friday before 12 pm). **Exceptions** to this policy can be determined only on an individual basis **(emergency situations)** according to the circumstances. These charges are allowed by your insurance company but considered as the patient's responsibility to pay.

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.

We believe that good communication is the key to excellence in dental care.

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

Patient name _____ **Date**_____

Signature _____

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Angelina Anisimova, D.D.S.
GENERAL DENTISTRY

HIPAA

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: (Family member/friend/relative):

_____

RELEASE OF RECORDS POLICY

In the event you need your dental records to be released to another dental office or an individual we require a release records form to be signed 2 business days in advance to the release. _____
Initials

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Angelina Anisimova Notice of Privacy Practices or the office staff member has asked me if I want a copy of it.

Patient name _____ **Date**_____

Signature _____**(if a patient is a minor , parent or legal guardian needs to sign this form)**

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