

# ANZILOTTI FAMILY DENTISTRY

Craig E Anzilotti, DDS

Chad G. Anzilotti, DDS

## Patient Information

Patient Name: \_\_\_\_\_ Preferred name: \_\_\_\_\_  
Last First M.I.

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone (home): (\_\_\_\_) \_\_\_\_\_ (Work): (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ (Cellular): (\_\_\_\_) \_\_\_\_\_

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

City State Zip Code

## Referral Information

Name of person or office referring you to our practice: \_\_\_\_\_

## Health Information

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

Please check any of the following that apply:

- |                                             |                                                |                                                            |                                               |
|---------------------------------------------|------------------------------------------------|------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Asthma/Emphysema      | <input type="checkbox"/> Heart Disease/Attack              | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Respiratory Problems |
| _____                                       | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hepatitis                         | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Latex Allergy      | <input type="checkbox"/> Diabetes- Type: _____ | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Codeine Allergy    | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Kidney Disease                    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Liver Disease                     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Mental Disorders                  | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Pacemaker                         | <input type="checkbox"/> Premedication        |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Head Injuries         | <input type="checkbox"/> <b>Pregnancy:</b> Due date: _____ | <b>OTHER:</b> _____                           |

List any medications you take: \_\_\_\_\_

• Have you ever had any complications during or 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: \_\_\_\_\_

In case of emergency: Contact \_\_\_\_\_ Phone: \_\_\_\_\_

To the best of my knowledge, all 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: \_\_\_\_\_

## Responsible Party Information (if different from patient information)

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Phone (home): (\_\_\_\_) \_\_\_\_\_ (Work): (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ (Cellular): (\_\_\_\_) \_\_\_\_\_

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

Street \_\_\_\_\_ Apartment # \_\_\_\_\_

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

## Employment Information

The following is for:  the patient  the person responsible for the patient

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

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

## Dental Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Patient's relationship to insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Patient's relationship to insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan and Address: \_\_\_\_\_

## 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.

Patients who carry dental insurance understand that all dental services furnished or 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 patient's insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account, however, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Service charge of 1 1/2% percent per month (18% per annum parentheses) 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 agreed to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within (5) days of billing. If credit shall be extended. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted here under.

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've read the above conditions of treatment and payment and agree to their content.

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

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# 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 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 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 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.

## **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 provider 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, 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 use 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 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 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.

**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 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).

## **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 \$0.30 for each page, \$15 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, 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 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 should 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 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 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.

**Anzilotti**

**Family Dentistry**

**275 N. Lindbergh Blvd., Suite 14**

**St. Louis, MO 63141**

**(314)993-8017**

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# Acknowledgement of Receipt of Notice of Privacy Practices

*\* You May Refuse to Sign This Acknowledgement\**

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have received a copy of the Notice of Privacy Practices of the office of Anzilotti Family Dentistry.

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Please Print Name

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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):