South Hill Periodontics

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PERSONAL HISTORY

Patient Name: _____ **Sex: M / F**

Social Security Number: ____/____/____ **Birth Date:** ____/____/____

Mailing Address: _____

City: _____ **State:** _____ **Zip code:** _____ **E-mail address:** _____

Home Number: _____ **Cell Number:** _____ **Work Number:** _____

Occupation: _____ **Patient Employer:** _____

Emergency Contact: _____ **Relationship to Patient:** _____

Home Number: _____ **Work Number:** _____

Referred by: _____ **Family Dentist:** _____

Have you or any member of your family been seen or treated by Dr. Giardino Y / N

PRIMARY DENTAL INSURANCE COVERAGE

Insurance Company: _____ **Phone Number:** _____

Subscriber Name: _____ **Group Number:** _____

Social Security Number: ____/____/____ **Birth Date:** ____/____/____

Employer: _____ **Work Number:** _____

SECONDARY DENTAL INSURANCE COVERAGE

Insurance Company: _____ **Phone Number:** _____

Subscriber Name: _____ **Group Number:** _____

Social Security Number: ____/____/____ **Birth Date:** ____/____/____

Employer: _____ **Work Number:** _____

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance company benefits to be paid directly to *South Hill Periodontics.* I am financially responsible for any balance due, including for services exceeding the limitations of my insurance policy. I authorize *South Hill Periodontics* to release any information requested for claims.

Signature of patient or legal guardian: _____ **Date:** _____

South Hill Periodontics, 2700 S. Southeast Blvd., Ste 210, Spokane, WA 99223

Office Phone: (509) 536-7032, Office Fax: (509) 536-7002

Dr. Anthony G. Giardino, D.D.S., M.S.

Dr. Michael A. Giardino, D.D.S., M.S.D

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____ H: _____ C: _____

Can we leave a detailed message at this number? YES NO

If no, please provide phone number _____

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of South Hill Periodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

South Hill Periodontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY) _____	YES	NO

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.

RELEASE OF BENEFITS AND INFORMATION

I also authorized my insurance company benefits to be paid directly to *South Hill Periodontics*. I am financially responsible for any balance due, including for services exceeding the limitations of my insurance policy. I authorize *South Hill Periodontics* or insurance company to release any information for claims

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.

Dated_____

Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name_____