South Hill Periodontics

ANTHONY G. GIARDINO, D.D.S., M.S. • *Diplomate, American Board of Periodontology*

2700 Southeast Blvd. • Suite 210 • Spokane, WA 99223 • Phone (509) 536-7032 • Fax (509) 536-7002

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* or insurance company to release any information requested for claims.

Signature of patient or legal guardian: ______________ Date: __________

PATIENT HEALTH HISTORY

Date ____________

Welcome to South Hill Periodontics! We appreciate the confidence you have in us to provide your periodontal needs. To assist us in serving you, please complete the following form. The information is important to your care. If there is any changes in your health, please tell us. We are always available to answer any of your questions.

Patient Name ____________ Date of Birth ____________ Age ____________

Physician's Name ____________ Date of Last Visit to Physician ____________

Dentist's Name ____________ Date of Last Visit to Dentist ____________

Height ____________ Weight ____________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems

- ☐ Chest Pain
- ☐ Blood Pressure Problem
- ☐ Heart Murmur
- ☐ Heart Valve Disorder (e.g., MVP)
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Previous Heart Attack
- ☐ Fast Heart Rate
- ☐ Other ____________

Blood Problems

- ☐ Bruise Easily
- ☐ Abnormal Bleeding
- ☐ Blood Disease (e.g. anemia)
- ☐ Other ____________

Allergy Problems

- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Other ____________

Intestinal Problems

- ☐ Ulcer
- ☐ Hiatal Hernia/GERD
- ☐ Other ____________

Bone or Joint Problems

- ☐ Arthritis
- ☐ Joint Replacement (e.g., total hip)
  Date ____________
- ☐ Other ____________

Lung/Breathing Problems

- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Problems Laying Flat
- ☐ Sleep Apnea
- ☐ Other ____________

Liver Problems

- ☐ Hepatitis
- ☐ Jaundice
- ☐ Other ____________

Other Medical Problems

- ☐ Fainting Spells, Seizures, Epilepsy, or Stroke
- ☐ Diabetes
- ☐ HIV Positive
- ☐ Glaucoma
- ☐ Cancer/Tumor
- ☐ Radiation Treatment
- ☐ Surgery in the last 6 months
  Date & Type ____________

Social History

- ☐ Do you drink? If so, how much? ____________
- ☐ Do you smoke? If so, how much? ____________
  How many years? ____________
- ☐ Do you chew tobacco? How often? ____________

Are you allergic or have you had a reaction to any of the following?

- ☐ Local anesthetics ("Novocaine")
- ☐ Penicillin
- ☐ Other Antibiotics ____________
- ☐ Aspirin
- ☐ Codeine
- ☐ Valium
- ☐ Demerol
- ☐ Other ____________

List of Medications including low dose aspirin, fish oil, Krill or herbs.

Women

- ☐ Are you taking contraceptives?
- ☐ Hormone Replacement Therapy?
- ☐ Is there a possibility you may be pregnant?

  No______

  Yes______ Date of Delivery____________________

DENTAL HEALTH HISTORY

Please Mark Any That Apply to You

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had previous periodontal treatment?
- ☐ Do your gums bleed when you brush and floss?
- ☐ Do your gums feel swollen or tender?
- ☐ Are your teeth sensitive?
- ☐ Do you prefer to save your teeth?
- ☐ How often do you brush?__________________________ How often do you floss? ___________________________
- ☐ Type of Brush: Standard _________________ Sonicare _________________ Other (electric) __________________
- ☐ Does your jaw make noise?
- ☐ Do you clench or grind your teeth?
- ☐ Does your jaw get stuck so that you cannot open freely?
- ☐ Do you have any jaw symptoms or headaches?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Do you have a temporomandibular joint disorder (TMD, TMJ)?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Are you a habitual gum chewer or pipe smoker?
- ☐ Do you have any disease, condition, or problem not listed previously that you feel we should know about?

  If so please describe:____

Date:_____________ Patient Signature: ______________________________ Dr. Signature:____________________________

DENTIST COMMENTS

Date	Blood Pressure Reading	Medical History Updated
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	Date____________________
____________________	______________________________	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.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name____

Patient number ____

Patient address ____

Patient phone number ____________________ H: ______________________ C: ____________________

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 Periododontics 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_________________________________

Source of Authority____

South Hill Periodontics

ANTHONY G. GIARDINO, D.D.S., M.S. Diplomate, American Board of Periodontology

Welcome to South Hill Periodontics and thank you for choosing us as your dental care provider. We understand dental treatment represents a significant investment both time wise as well as financially. We are committed to addressing both the emotional as well as the financial aspects of your dental treatment in our office.

Regarding Payment:

We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, and Care Credit.

Payment for services are due at the time the services are rendered, this includes all insurance co-pays and deductibles. Any additional account balance after insurance payment has been received is due within 30 days.

Regarding Insurance:

It is important to understand that dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental treatment. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. Your "Insurance" may cover a portion of a specialist's treatment but more often than not your benefits are better utilized with your routine treatment in your general dentist's office. This can result in more out of pocket expense with the specialist.

Whatever benefits you have coming, we will make sure you get them. We will work closely with your general dentist to maximize your benefits and minimize your out-of-pocket expenses. We will also never let the insurance companies dictate what we can, or cannot recommend to you as our patient based on your diagnosis. We will tell you exactly what services are needed in order to treat and or/control the diagnosed condition.

We will do our best to give you an accurate estimate, but remember it is exactly that, an estimate. Rest assured that we are on your side and will always do our best for you.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party:_________________________________ Date:______________

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