PATIENT INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____

PATIENT SS#: _____ SEX: _____ MARITAL STATUS: _____ DRIVER'S LICENSE: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: (____) _____ CELL#: (____) _____ **Email:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE#:** (____) _____

Race Circle Asian Native American White African American Hispanic Other Native Hawaiian Refuse to Answer

Ethnicity Circle Black Hispanic/Latino Non-Hispanic or Latino Refuse To Answer

Language Circle English Spanish Other

PRIMARY INSURANCE INFORMATION

PLEASE CIRLE ONE

INSURANCE COMPANY'S NAME: _____ HMO PPO POS OTHER

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP #: _____ GROUP NAME: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S SOCIAL SECURITY #: _____ INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER'S PHONE #: (____) _____ OCCUPATION: _____

SECONDARY INSURANCE INFORMATION

PLEASE CIRLE ONE

INSURANCE COMPANY'S NAME: _____ HMO PPO POS OTHER

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP #: _____ GROUP NAME: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

INSURED'S SOCIAL SECURITY #: _____ INSURED'S EMPLOYER: _____

NEXT OF KIN INFORMATION

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: (____) _____ WORK #: (____) _____ CELL #: (____) _____

RELEASE AND ASSIGNMENT OF BENEFITS

I AUTHORIZE GIACOMO S GUGGINO MD PA TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED. PRIVATE INSURANCE AND ANY OTHER NON-GOVERNMENT SPONSORED PROGRAMS TO GIACOMO S GUGGINO MD PA. A PHOTOCOPY OF THIS ASSIGNEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE COMPANY.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AND IN THE EVENT IT BECOMES NECESSARY TO INSTITUTE LEGAL PROCEEDING TO COLLECT THE SUMS DUE, THEN THE PATIENT OR RESPONSIBLE PARTY SHALL BE RESPONSIBLE FOR ANY AND ALL COURT COSTS AND REASONABLE ATTORNEY FEES PLUS COLLECTION AGENCY FEES. I AUTHORIZE GIACOMO S GUGGINO MD PA TO OBTAIN A CREDIT REPORT AND INVESTIGATE MY CREDIT SHOULD PAYMENT ARRANGEMENTS BE NECESSARY.

SIGNATURE _____ **DATE** _____

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Giacomo S. Guggino, M.D., P.A., and Its Affiliated Providers and/or Subsidiaries and/or affiliated companies to view my external prescription history.

I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Signature of Patient (or Legal Representative) **Date**

_____

Print Name

_____

Relationship to Patient

3109 Swann Ave
Tampa, FL. 33609

HIPAA Release

Patient Name: _____
Last **First** **MI**

Patient SSN: _____ **Patient DOB:** _____ **Age:** _____

Street Address: _____ **Apartment No.** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Disclosure Election:
You may disclose my health information to the following:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Entire Record. Unless specified, the records to be released may include (if applicable) HIV/AIDS testing, results, and/or treatment records; Mental Health treatment, records, and notes; Alcohol and/or drug abuse treatment records.

I understand if I revoke this authorization I must do so in writing and present my written revocation to the office or mail to the address below. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. I understand this information may be released to Giacomo S Guggino MD PA and/or affiliates, subsidiaries, or any other entities in regards to your health record. If I have any questions about the disclosure of health information, I can contact the office at 813-876-1400.

_____ I revoke this authorization. _____
Signature

_____ _____
Authorize to Release **Signature of Witness**
Signature of Patient (or Legal Representative)

_____ _____
Relationship to Patient **Date**

3109 Swann Ave
Tampa, FL. 33609

Giacomo S. Guggino, M.D., P.A.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Practices of Giacomo S Guggino, MD, PA*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change at any time. If we change our notice, the new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised *Notice of Privacy Practices*. To receive the most current *Notice of Privacy Practices*, you may call our office at (813) 876-1400 and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

If you have any questions about our *Notice of Privacy Practices*, please contact:

Valerie Holland, Practice Manager
Giacomo S Guggino, MD, PA
3109 Swann Ave
Tampa, FL
(813) 876-1400

I acknowledge receipt of the *Notice of Privacy Practices of Giacomo S Guggino, MD, PA.*

Signature: _____ **Date:** _____
(*Patient/Parent/Conservator/Guardian*)

Print Name: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

Print Name: _____

Health Survey

Name:_____

Social Security Number:_____ Date of Birth_____

Please tell us which physician(s) we should contact regarding your visit:

REFERRING PHYSICIAN

Name: _____

Address:_____

_____

Phone:_____

Fax:_____

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

_____

Phone:_____

Fax:_____

PHARMACY

Name: _____

Address:_____

_____

Phone:_____

Fax:_____

ADDITIONAL PROVIDERS

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

What Medications do you take?

☐ NO Medications

Please include all current medications including diet aids, herbs, over the counter drugs (aspirin, arthritis pain relievers, Tylenol etc), prescription drugs, oral contraceptives, recreational drugs, laxatives, tonics, vitamins, and other minerals.

Name of Medicine	Dose (mg)	How Many Times Per Day

ALLERGIES AND REACTION

☐ NO KNOWN ALLERGIES

_____ _____

_____ _____