Patient Registration - Gupta ENT Center
www.guptaentcenter.com

Please Furnish Insurance Cards and a Picture ID / Driver's License

Patient Name____Age___________Birth Date____________________

Primary Care Physician:________________________________City:______________Office Phone:____________________

Please Circle: Male / Female Social Security#:______________________Marital Status: S M D W Other

Patient's Home Address:____City___________________State_______________

Patient's Home Phone:__________________________________Cell Phone:_______________________________________

Patient Email Address:____FaceBook:__________________________________

Patient's Employer:____Work Phone:_____________________________

Work Address:_____________________________________If self-employed, name of business:_______________________

Spouse Name:_________________________________Birthdate:___________________Social Security#:________________

Spouse Employer:____Work Phone:_______________________________

If patient is under parent/guardian's insurance:
Patient/Guardian Name__________________________________Birthdate:_______________Social Security#:____________

Address:___________________________________City:______________________________State:____________________

Phone:_________________________Cell Phone:________________________Email:_________________________________

Employer:____Work Phone:_______________________________________

Other Parent/Guardian Name:______________________________Birthdate:_______________Social Security#:____________

Employer:____Work Phone:_______________________________________

Insurance Information
Name of Primary Insurance:_________________________________Contract#____________________________________

Subscriber's Name:___________________________________Patient Relation to Subscriber:__________________________

Secondary Insurance (Supplemental Policy):_____________________________Contract#______________________________

Patient Pharmacy Name:_____________________________City:______________________Phone:_____________________

Emergency Contact Name:_______________________________Phone:____________________Relation:_______________

I / We authorize the physician to:

1.) Leave a message on my/our home phone. Yes ❑ No ❑
2.) Speak to a family representative Yes ❑ No ❑
regarding test results and subsequent recommendations. Exceptions are:____________________________________

Under our professional and ethical obligations we are required to maintain physician-patient confidentiality and your privacy. Privacy policies of the Gramm-Leach-Bilely Act insure our professional and ethical obligations to you. Any release of information requires a separate written and signed authorization from the patient or legal guardian. _______________(Initial)
Signing of this document provides only consent for treatment at this time and forward until revoked in writing by the patient or legal representative.
____(Sign & Date)

I hereby authorize payment directly to the physician for the medical and/or surgical services. I understand that if the physicians of this office are not providers of my insurance, or if I am not covered by insurance, then payment for services are my full responsibility. I agree to pay bank, credit bureau and office billing expenses for any delinquent accounts. I authorize the physicians of this office to release any information in the course of treatment to only the insurance company. I have read and fully understand this insurance assignment and agreement.

____
Patient Signature /or Legal Guardian if patient is a minor Date

Please Circle: Mr. Mrs. Miss Ms Patient Name:__________________________Date of Birth__________

Referred By:______________________ Primary Care Physician__________________________

Review of Systems

Yes	No	***Cardiovascular***
❑	❑	Heart Attack
❑	❑	Angina (Chest Pain)
❑	❑	High Blood Pressure
❑	❑	Mitral Valve Prolapse
❑	❑	Heart Failure
❑	❑	Irregular Heartbeat
❑	❑	Heart Murmur
❑	❑	Other

Yes	No	***Respiratory***
❑	❑	Asthma or wheezing
❑	❑	Sleep Apnea
❑	❑	Chronic Lung Disease
❑	❑	Emphysema
❑	❑	Snoring
❑	❑	Other

Yes	No	***Renal (Kidney)***
❑	❑	Kidney Failure
❑	❑	Other

Yes	No	***Hepatic (Liver)***
❑	❑	Hepatitis
❑	❑	Other

Yes	No	***Endocrine***
❑	❑	Diabetes
❑	❑	Thyroid Disease
❑	❑	Other

Yes	No	***Neurologic***
❑	❑	Seizures
❑	❑	Stroke
❑	❑	Other

Yes	No	***Gastro-Intestinal***
❑	❑	Hiatal Hernia/Reflux
❑	❑	Bowel Obstruction
❑	❑	GI Bleeding
❑	❑	Other

Yes	No	***Hematologic (Blood)***
❑	❑	Sickle Cell
❑	❑	Bleeding Disorder
❑	❑	Transfusion
❑	❑	Other

Yes	No	***Pediatric (if applies)***
❑	❑	Abnormalities at birth
❑	❑	Premature
❑	❑	Birth weight__________
❑	❑	How early__________
❑	❑	Sleep Apnea (Breath holding)
❑	❑	Snoring

Yes	No	***Allergy***
❑	❑	Previous Allergy Testing
❑	❑	Previous Allergy Shots
❑	❑	Environmental (dust, mold)
❑	❑	Seasonal (trees, grass, pollens)
❑	❑	Food Allergies

Past Medical and Social History

Please list all the medications you currently are taking:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please list any medication allergies and the reactions you've had to them:______________________

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Past Surgical History:____

Are you currently pregnant?______________ Are you HIV positive or at risk?______________

Do you use alcohol?________ How often?________ Do you sleep well?______________

Do you smoke?________ How often?________ Have you had cancer?______________

Briefly explain any YES answers and/or any other medical conditions you may have:______________

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Patient Signature / Legal Guardian if patient is a minor Date