Registration :											K Kantu, MD
						1	i i i i i i i i i i i i i i i i i i i				
Patient Information Last Name	First Name			Middle	Gender	Marita	al Status	Birth	ndate	Age	Social Security #
Address	egy de constante en 1860 de 18	naugu viði viðjað viðstjóður rekklis resillaussan	ettimetel var tim svigstiftete som med en	managementace of the last	Home: Work:	Egiption straped Brownia until resolution des	kal jamen kindi kajal sessen nega seset lili seleti		How did you h	ear of us?	
and the state of the second of	karalatur bili begir u sekere ekseke rekike bilike bilike araban salak sekere sebi	to process to to the enclosing control of the	HEREKARAN PERSERPEN ANG	an na san an ing ang ang ang ang ang ang ang ang ang a	Cell:	1866 Militaria (ila espar medificacia) a rein	- Selson An Charlis dall IV Carrigip Asseque	MANAGE STREET, A 1 P. A 1 P.	milliones the Massedown ill in our actions site are underly galaxy.	I THE SALES SEE SEE SEE SEE SEE	ethellowin die Oldriff die voormonde endeling verlaging his konde hat bestegelijk verge ver
Ap+#	N 34 Ку-17 на файнатуру поских или раводовичную	Chata	7:- 0-	ANTENNE STRUKTURE	Email:	r Name & A	ddroce	tterre d'un comme en 1979	horinga (Meeslebin) statistis oktobelja gaatasiya ya		oriente una consecuentamente accessionent con a consecuent accessionent con a consecuent accessionent accessi
, only		State	Zip Co	ue	Linploye	r Hame & A	aaress			- consequent species follows	
Emergency Contact	An Lauri Padh an Pap ipa P ilibadh ath ath indurence mas a choirm by balaiteán	Phon	e	eletti kuri elektrisi ya kunduka kek	Pharmad	Cy	yddy yr fe'r reinioledd y gellei hydd y y c enodddillei	K F F Pro SANKARA	elektronia terriyek ili e ilin erili vali iyili kibi il	a van ann amhar ceantachtaig Siabhan	Pharmacy Phone
Physician		Fa	mily Ph	ysiciar	1.73 07 48	Carriera Market	Refe	rring	Physician		
Medical Insurance	Name & A	ddres	s P	olicyho	older		1995	Relati	ionship Po	licy ID	Group ID
1		in ale									
as balances of closes to applicate the terminative of the community of the selection of the community of the	a, and a construction of the second of the s	haqadhiden kranecare dal		ing Phongs of Miller years bloom when even the	er talangahaja, seranggi prospirant an gastiga deri 1900	enegatika erin selman erin olumbar erinde erin olumbar erinde erin olumbar erinde erinde erinde erinde erinde e	- Commercial Section Artists, in 2008	.00. '00-'00-; '00-00-00-00-0	Commence of the same of the sa	i v na Milliong tananak yan vi yan a vindano vi	mark kraudilikuli 200 khody kadina disaksi an russi providanni susia. Sussessi
2			menteriore inhandamento.				Signal Space delimentary personal		eljes program og eller gjernen se		une - Dija, e e e e emilija
3	2,784 e in Christian (Statistical administration) and christian (Christian)	orlandi vijeku v skoli koju zadkoli r		enthus agus shini di cualit (1979) di ililiando	n kanada kan	gweith was green either governor en	emercelle et transce to grant et en	vxxxxdviikmyqaddii	Holosourum gesta haddolfasi ja ki kanaanana.	Peru anter la collega des Resu anterio porto de Asia.	Commence at 45° a 200 a 100 a
Guarantor (Person to be	billed, if diffe	rent th	an patie	nt)						î-Wata	
1 Last Name	First Name	ragica (fariabata Princ	an Control of the Section of Section 1995	Middle	Gender	Marita	ıl Status	Birthda	ate		Social Security #
Address	E 25 sago et escreta comunicación a contrato de estableción de la contrato del contrato de la contrato de la contrato del contrato de la contrato del la contrato de la contrato del la contrato de la contrato de la contrato de la contrato de la co	all the last of the last of the first of the	46 Ph. 18 48 24 Ph. 15 27 18 Ph. 18 P	ila matumoropoiae	Home:	entronector en ligitar en la recent	and the second of the second of	Work:	1986-yil amerikan elektron - sayetaren balik kibibaki	Email	C. C
City	y - en e yellengelende 1900 en volktillen i Childelth Schollbedt	State	Zip Code	Employ	er Name &	Address	Part was a straightnesses	den a dy Sterner () week	fato - Albanian arthrofala e e arreald altres d'Arac e c'h	Occup	ation
2. Last Name	First Name	\$		Middle	Gender	Marita	al Status	Birthd	ate	į	Social Security #
Address	un Desgradus (1 min en 140 PS (1884) e cencembris (Microbiologic March Inspire Charmer	Si Dessi Paparisi Paparisi na mining at sa mangana na mining at sa mangana na mining at sa mining at sa mining	gangana nganggan tanta sasa anta-	Home:	aandeleersteers der van ³ e van een van de Heinen van de	in Water Statement and the Wa	Work:	en komonikilisensingakkonsklerne up pen ennighern	Email	g g Salaga kang sebagahar mang mang mengan samatan digiti 22 ataun 1944 mengan 1950 mengan Salaga kang sebagahar mengangkan sebagai samatan digiti 22 ataun 1951 mengan sebagai sebagai sebagai sebagai
City	ে কাল হ'ত নাম বিশ্ববিধার প্রথমিক প্রথমিক ক্রিক্টি প্রথমিক করা বা ইনিই ইনিই ইনি	State	Zip Code	Employ	er Name &	Address	and the land of the section of the s	вания выдает ст	o eminente a antidocardo Piñrel - diferencia de PP desentacione	ysz n. naffinkaran karalasa saaki sa	Occupation
HIPAA Approved Contact 1. Last Name	s First 'Vame		Mi	ddle Ger	nder Bi	rthdate	Socia	al Secu	rity#		Relationship
Address	pular a museum a maria carriera de la Co	ity	to the the second second second	ng acragaeal earnainne	State	Zip Code	Home) :	Cell:	y = 1 nds.29ede/1086758	Work:
2.Last Name	First Name		Mi	ddle Ger	nder B	irthdate	Socia	al Secu	rity #		Relationship
Address		City	K. 100,000, Nr. 02, (VO. Pro-Pro	en situate de la procesa de la constante de la	State	Zip Code	Home	e:	Cell:	ig t (dha histogri	Work:
Patient's or Authorized F	Person's Sign	ature		Jan Japan							
I the undersigned give my au rendered. I understand that I authorize the doctor to releas submissions. I understand tha	am ultimately fir e all informatior	nancially necess	respons sary to se	ible for a cure the	all approv payment	ed and co	vered ch	arges	whether or n	ot paid b	y insurance. I hereby
I acknowledge receipt of the I of treating me, obtaining payr	ment for service	s rende	red to me	ices. I a , and co	nducting	healthcare	operati	and d ons.	lisclose my ho	ealth info	rmation for purposes
Signature X	S	ignature	Date		220	Kantu, M 04 Voorhie	s Avenu	е		Pho	ne: 718-646-2500
	Please	attach	all nerti	nent in	State Line Notes	oklyn, NY e ID card		hotor	copying.		Email:

My Center For Ear, Nose, Throat, Sinus & Allergy, LLP

KANHAIYALAL KANTU, M.D., F.A.C.S. SANJAY KANTU, M.D. MANOJ KANTU, M.D. DIPLOMATES AMERICAN BOARD OF OTOLARYNGOLOGY

SINUS & ALLERGY FACIAL PLASTIC SURGERY HEARING & BALANCE DISORDERS SNORING & SLEEP APNEA HEAD & NECK SURGERY

MEDICAL HISTORY

Today's Date	Birth date (MM/DD/YYYY)					
Name:						
Last	First					
ALLERGIES DNONE	□YES - PLEASE LIST					
LIST CURRENT MEDICATIO	NS (include all non-prescription	medications you take)				
PLEASE CHECK CURRENT/C	CHRONIC MEDICAL CONDITI	ONS □ NONE				
□acid reflux	□depression	□high cholesterol	□thyroid disease			
□anemia	□emphysema	□HIV	□tuberculosis			
□anxiety	□gallbladder	□irregular heart beat	□ulcers			
□arthritis	□glaucoma	□kidney				
□asthma/allergies	□gynecologic dis.	□migraine				
□bleeding/clotting disease	□lupus	□parathyroid disease				
□breast disease	□headaches	□pneumonia				
□bronchitis	□heart attack date	_□rheumatoid arthritis				
□cancer of	□heart disease	□sarcoidosis				
□chronic lung disease	□hepatitis B	□seizures/epilepsy				
□COPD	□hepatitis C	□skin condition (eczema/psoriasis)				
□diabetes	□high blood pressure	□stroke date				
OTHER MEDICAL CONDITI	ONS:					
SURGERIES (DESCRIBE TYPE	E & YEAR)					
Tobacco Usage: □ NO □Y	ES. If yes: PACKS PER D.	AY				
Alcohol Use: □NO □Ye	es. If Yes, □Occasional	□Weekly □Daily				
Patient Signature						

NY Center For Ear, Nose, Throat, Sinus & Allergy, LLP

KANHAIYALAL KANTU, M.D., E.A.C.S. SANIAY KANTU, M.D. MANOJ KANTU, M.D. DIPLOMATES AMERICAN BOARD OF OTOLARYNGOLOGY

SINUS & ALLERGY FACIAL PLASTIC SURGERY HEARING & BALANCE DISORDERS SNORING & SLEEP APNEA HEAD & NECK SURGERY

NOTICE OF PRIVACY PRACTICES --- PATIENT ACKNOWLEDGEMENT

1 4	OTICE OF TRAVEL PROTECTIONS TATIENT ACKNOWED DOES TENT
Patient's Name	: Date of Birth:
in detail, the us	this Practice's Notice of Privacy Practices written in plain language. The Notice provides, ses and disclosures of my protected health information that may be made of this Practice, rights, and the Practice's legal duties with respect to my protected health information. The second
 inform A state Types purpos A desc disclos A desc A desc A desc My inc 	ment that this Practice is required by law to maintain the privacy of protected health ation. ment that this Practice is required to abide by the terms of the Notice currently in effect. of uses and disclosures that this Practice is permitted to make for each of the following est treatment, payment, and health care operations. ription of the other purposes for which this Practice is permitted or required to use or expretected health information without my written consent or authorization. ription of uses and disclosures that are prohibited or materially limited by law. ription of other uses and disclosures that will be made only with my written authorization at I may revoke such authorization. Rividual rights with respect to protected health information and a brief description of how I se their rights in relation to: The right to complain to this Practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a compliant. The right or request restrictions on certain uses and disclosures of my protected health information, and that this Practice is not required to agree to a requested restriction. The right to receive confidential communications of protected health information. The right to inspect and copy protected health information.
new pi	The right to amend protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of the Notice of Privacy Practices from this Practice upon request. Tactice reserves the right to change the terms of its Notice of Privacy Practices and to make povisions effective for all protected health information that it maintains. I understand that I
	tain this Practice's current Notice of Privacy Practices on request.
~-0	

My Center For Ear, Nose, Throat, Sinus & Allergy, LLP

KANHAIYALAL KANTU, M.D., F.A.C.S. SANJAY KANTU, M.D. MANOJ KANTU, M.D. DIPLOMATES AMERICAN BOARD OF OTOLARYNGOLOGY

SINUS & ALLERGY FACIAL PLASTIC SURGERY HEARING & BALANCE DISORDERS SNORING & SLEEP APNEA HEAD & NECK SURGERY

Welcome to our Ear, Nose, and Throat Practice.

Please circle those items below that best describe your reasons for being here :

Hearing loss

Ear pain or itching

Ringing in the ears

Dizziness

Allergies

Sinus problem

Nasal congestion

Throat problem

Neck problem

Thank you!

Dr Kantu

Your signature below forms a binding agreement between NY CENTER FOR E.N.T and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service. MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform NY CENTER OF E.N.T of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- · Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

1

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that NY CENTER OF E.N.T. has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)	Patient Signature		
	Date		
Responsible Party Name (Please Print)	Responsible Party Signature		
	Date		





AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		
I, or my authorized representative, request that health in	nformation regarding my care and treatment	be released as set forth on this form:
In accordance with New York State Law and the Privac (HIPAA), I understand that:		
1. This authorization may include disclosure of info TREATMENT, except psychotherapy notes, and CON the appropriate line in Item 9(a). In the event the healt initial the line on the box in Item 9(a), I specifically aut 2. If I am authorizing the release of HIV-related, alcoroprohibited from redisclosing such information without understand that I have the right to request a list of peop I experience discrimination because of the release or did of Human Rights at (212) 480-2493 or the New Yor responsible for protecting my rights. 3. I have the right to revoke this authorization at any revoke this authorization except to the extent that action 4. I understand that signing this authorization is volbenefits will not be conditioned upon my authorization for the conditioned upon my authorization migredisclosure may no longer be protected by federal or state. This Authorization Does not Authorization Does not Authorization Does with Authorization Does not Authorization Does	IFIDENTIAL HIV* RELATED INFORM the information described below includes any thorize release of such information to the per tholor or drug treatment, or mental health tr tot my authorization unless permitted to de the who may receive or use my HIV-related sclosure of HIV-related information, I may the City Commission of Human Rights at (time by writing to the health care provider I that already been taken based on this author that already been taken based on this author that disclosure. The recipient (except that be redisclosed by the recipient (except that law. RIZE YOU TO DISCUSS MY HEALTH ORNEY OR GOVERNMENTAL AGENT	IATION only if I place my initials on y of these types of information, and I rson(s) indicated in Item 8. eatment information, the recipient is lo so under federal or state law. I information without authorization. If contact the New York State Division (212) 306-7450. These agencies are listed below. I understand that I may orization. In a health plan, or eligibility for as noted above in Item 2), and this HINFORMATION OR MEDICAL
7. Name and address of health provider or entity to rele8. Name and address of person(s) or category of person		
8. Name and address of person(s) or category of person	to whom this information will be sent:	
9(a). Specific information to be released:	to (income data)	
☐ Medical Record from (insert date) ☐ Entire Medical Record, including patient histor referrals, consults, billing records, insurance re	ies, office notes (except psychotherapy note	s), test results, radiology studies, films
Other:		ndicate by Initialing)
	***************************************	Alcohol/Drug Treatment
	Non-tri-command and the second	Mental Health Information
Authorization to Discuss Health Information	The state of the s	HIV-Related Information
(b) By initialing here I authorize		
Initials to discuss my health information with my attorne	Name of individual health or a governmental agency, listed here:	care provider
(Attorney/Firm	Name or Governmental Agency Name)	
10. Reason for release of information: At request of individual	11. Date or event on which th	nis authorization will expire:
Other:		

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

13. Authority to sign on behalf of patient:

Signature of patient or representative authorized by law.

12. If not the patient, name of person signing form:

^{*} Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.