

PATIENT REGISTRATION

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX:  M  F

REFERRING DOCTOR NAME: \_\_\_\_\_  
(first) (last)

PATIENT NAME: \_\_\_\_\_  
(first) (last)

ADDRESS: \_\_\_\_\_ APARTMENT #: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  MARRIED  SINGLE

TELEPHONE # (home): \_\_\_\_\_ (work): \_\_\_\_\_ ext. \_\_\_\_\_

(cell): \_\_\_\_\_ (email): \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ BIRTH DATE(mm/dd/yyyy): \_\_\_\_\_

EMERGENCY CONTACT: NAME: \_\_\_\_\_  
(first) (last)

RELATIONSHIP: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

PATIENT EMPLOYER NAME & ADDRESS: \_\_\_\_\_

INSURANCE NAME (primary): \_\_\_\_\_ INSURANCE ID NO: \_\_\_\_\_

INSURANCE (secondary): \_\_\_\_\_ INSURANCE ID NO: \_\_\_\_\_

IF THE INSURANCE IS NOT IN YOUR NAME PLEASE COMPLETE THE FOLLOWING

RELATIONSHIP TO INSURED  Husband  Wife  Parent Telephone #: \_\_\_\_\_

NAME OF PERSON INSURED \_\_\_\_\_  
(first) (last)

SOCIAL SECURITY OF INSURED: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

How did you find us?  Friend/family/coworker  Internet listing  Referred by my doctor  
 Insurance listing  Other: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION** I will fully authorize Rakesh Gupta Medical, P.C. and Gupta Gastro Associates' employees to access the information provided. I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize this office to apply for benefits on my behalf for covered services rendered by the physician(s) in and out of network. I request that payment from my insurance company be made directly to the physician(s) or to the party who accepts assignment. I certify that information I have reported with regard to my insurance coverage is correct and active. I understand I will be held responsible for any services not paid by the insurance company which I have listed above.

SIGNATURE: \_\_\_\_\_