RAKESH GUPTA MEDICAL, P.C. & GUPTA GASTRO ASSOCIATES PATIENT REGISTRATION

ALL INFORMATION MUST BE FULLY COMPLETED AND UPDATED REGULARLY

DATE:__________________ SEX: ❒ **M** ❒ **F**

REFERING DOCTOR NAME:____
(first) (last)

PATIENT NAME:____
(first) (last)

ADDRESS:______________________________**APARTAMENT #:**________________

CITY:____________________________**ZIP:**________________ ❒ **MARRIED** ❒ **SINGLE**

TELEPHONE # (**home**):__________________(**work**):__________________ext.__________

(**cell**):______________________________(**fax**):______________________________

SOCIAL SECURITY:________________________**BIRTH DATE(mm/dd/yyyy):**________________

PATIENT EMPLOYER NAME & ADDRESS:____

INSURANCE NAME (**primary**):__________________**INSURANCE ID NO:**________________

INSURANCE(secondary):__________________**INSURANCE ID NO:**________________

EMERGENCY CONTACT: **NAME:**____
(first) (last)

RELATIONSHIP:________________________**TELEPHONE NO:**________________________

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

NAME OF PERSON INSURED (husband,wife or parent):________________________________

INSURED'S EMPLOYER NAME AND ADDRESS:________________________________

RELATIONSHIP TO INSURED:________________COPAY AMOUNT:$__________DEDUCTABLLE:$__________

SOCIAL SECURITY OF INSURED:________________________BIRTHDAY:________________

How did you find us? Who should we thank?:________________________________

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). 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. I understand I will be held responsible for any services not paid by the insurance company which I have listed above.

SIGNATURE:____ Document created on:12/29/06