Subhash Gupta, MD / Mrinal Garg, MD
601 E. Sample Road, Suite 105
Pompano Beach, Florida 33064

# PATIENT REGISTRATION FORM

PATIENT NAME:_____PHONE:_____
FIRST MIDDLE LAST

CELL:_____

ADDRESS:_____
STREET APT# CITY STATE ZIP

DATE OF BIRTH:_____SOCIAL SECURITY #:_____SEX: M / F Marital status:___

RACE: □Black □Caucasian □Hispanic □Asia Pacific American □Pacific Islander □American Indian/Native Alaskan □Other

EMAIL:_____

EMPLOYER: _____ WORK PHONE:_____

ADDRESS:_____ OCCUPATION:_____

**REFERRING PHYSICIAN**:_____MD/DO
FIRST NAME LAST NAME (Circle one)

REF. PHYSICIAN ADDRESS:_____PHONE:_____

**PRIMARY CARE PHYSICIAN**:_____MD/DO
FIRST NAME LAST NAME (Circle one)

PCP ADDRESS:_____PHONE:_____

**EMERGENCY CONTACT**:_____RELATIONSHIP:_____

ADDRESS:_____PHONE:_____

□Medicare □Medicaid □Commercial □Self Pay □Other_____

**PRIMARY INSURANCE NAME**:_____POLICY#_____

GROUP #:_____SUBSCRIBER NAME:_____DOB:_____

SUBSCRIBER SS#:_____ SUBSCRIBER EMPLOYER:_____

**SECONDARY INSURANCE NAME**:_____POLICY #:_____

GROUP #:_____SUBSRUBER NAME:_____DOB:_____

SUBSCRIBER SS#:_____ SUBSCRIBER EMPLOYER:_____

**PHARMACY NAME**:_____PHARMACY PHONE:_____City/State:_____

AUTHOTIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

**SIGNATURE**:_____ **DATE**:_____

Subhash Gupta, MD / Mrinal Garg, MD
601 E. Sample Road, Suite 105
Pompano Beach, Florida 33064

# MEDICAL AND FAMILY HISTORY FORM

NAME:_____DATE OF BIRTH:_____TODAY'S DATE:_____

Chief Complaint:_____

Referring Physician Name: _____

**Medications** – Please list all of your current prescription and non-prescription medications, vitamins, and supplements:
□None

| Medication Name | Dosage | Medication Name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies**
□None □Penicillin □Sulfa □Aspirin □Iodine □Latex □Others:_____

**Past Medical History**

| | | | | |
|---|---|---|---|---|
| □Anemia | □Colon polyps | □Gallbladder disease | □Irritable bowel | □Prostate enlargement |
| □Arthritis | □Congestive Heart | □Gastritis | syndrome | □Psoriasis |
| □Asthma | Failure | □GERD (reflux) | □Kidney disease/failure | □Rheumatic fever |
| □Atrial Fibrillation | □Constipation | □GI bleeding | □Liver disease | □Sciatica |
| □Barrett's Esophagus | □COPD | □Heart attack | □Neurologic disorders | □Seizures |
| □Bleeding disorder | □Coronary Artery | □Heart murmur | □Osteoporosis | □Sleep apnea |
| □Blood transfusion | Disease | □Hepatitis | □Ovarian cyst | □Stroke |
| □Cancer | □Crohn's disease | □Hiatal hernia | □Pancreatitis | □TB (tuberculosis) |
| □Chronic anxiety | □Depression | □High blood pressure | □Parkinson's disease | □Thyroid disorders |
| □Chronic sinusitis | □Diabetes | □High cholesterol | □Peptic ulcer | □Ulcerative colitis |
| □Cirrhosis | □Diverticulosis | □HIV or AIDS | □Phlebitis | □Valvular heart disease |
| □Colon cancer | □Fatty liver | □Irregular heart beat | □Pneumonia | □Other_____ |

**Previous Hospitalizations**

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Surgeries/Procedures**

| | | | |
|---|---|---|---|
| □Appendectomy | □EGD | □Liver biopsy | □Thyroid surgery |
| □Barium Enema | □ERCP | □MRI | □Tonsillectomy |
| □Breast surgery | □Gallbladder surgery | □Obesity surgery | □Tubal ligation |
| □Capsule endoscopy | □Heart bypass | □Ovarian surgery | □Ulcer surgery |
| □Cholecystectomy | □Heart valve replacement | □Pacemaker placement | □Ultrasound |
| □Colon surgery | □Hemorrhoids surgery | □Prostate (TURP) | □Upper GI series X-ray |
| □Colonoscopy | □Hiatal hernia repair | □Radiation therapy | □Uterine surgery |
| □Colostomy | □Hysterectomy | □Sigmoidoscopy | □None |
| □C-section | □Joint replacement | □Small bowel resection | |
| □CT scan | □Kidney surgery | □Stomach surgery | |

Other_____

**Family History**

| | Father | Mother | Sister/Brother |
|---|---|---|---|
| Healthy/Alive | □ | □ | □ |
| Deceased | □ | □ | □ |
| Colon polyps | □ | □ | □ |
| Colon cancer | □ | □ | □ |
| Gastric ulcer disease | □ | □ | □ |
| Liver disease | □ | □ | □ |
| Pancreatic disease | □ | □ | □ |
| Crohn's disease | □ | □ | □ |
| Ulcerative colitis | □ | □ | □ |
| Stomach cancer | □ | □ | □ |
| Diabetes mellitus | □ | □ | □ |
| Heart attack | □ | □ | □ |
| Breast cancer | □ | □ | □ |
| Other cancer | □ | □ | □ |

**Social History**

Marital status: □married □single □divorced □widowed

Occupation: _____ □unemployed □retired

Smoking history: □never □yes_____packs per day for_____years □ Quit (how long)_____

Other tobacco: use □no □yes; details:_____

Alcohol use: □no □yes; amount per day _____for_____years

Drug use: □no □yes; specify drugs:_____

Exercise habits: □no □yes; how much and how often:_____

Recent travel outside US: □no □yes: where:_____

Caffeine use: □no □yes

**Review of Systems** – check all that apply at the present time

General
- Chills
- fever
- Loss of appetite
- Night sweats
- Weight gain
- Weight loss
- Feel tired or poorly

Eyes
- Worsening vision
- Blurred vision
- Vision distortion
- Eye pain

Otolaryngeal symptoms
- Earache
- Nasal discharge
- Mouth sores
- Bleeding gums
- Hoarseness
- Throat pain
- Facial pain
- Sinus pain

Cardiovascular
- Chest pain/discomfort
- Fast heart rate
- Swelling of legs
- Varicose veins

Respiratory
- Chronic cough
- Wheezing
- Shortness of breath

Gastrointestinal
- Abdominal swelling
- Abdominal pain
- Belching
- Black stools
- Red blood in bowel movement
- Change in bowel movement frequency
- Constipation
- Diarrhea
- Difficult swallowing
- Fatty food intolerance
- Full after eating small meals
- Gas/bloating
- Heartburn
- Hemorrhoids
- Yellow skin or eyes
- Nausea
- Pain with swallowing
- Decrease in appetite
- Rectal bleeding
- Rectal pain
- Regurgitation of food
- Incontinence of stool
- Vomiting
- Vomiting blood

Musculoskeletal
- Joint pain
- Joint stiffness
- Swollen joints
- Low back pain
- Muscle pain

Skin symptoms
- Pruritus (itching)
- Skin lesions
- Rashes

Neurologic
- Numbness or tingling
- Dizziness/ lightheadedness
- Vertigo
- Headaches
- Weakness in arms/legs
- Memory lapse or loss

Psychiatric
- Anxiety
- Depression
- Panic attacks
- Loss of sleep

Endocrine
- Heat or cold intolerance
- Excessive thirst
- Excessive urination
- Hot flashes

Hematologic/lymphatic
- Easy bruising tendency
- Swollen glands
- Nosebleeds

Urinary
- Pain or difficulty with urination
- Frequent urination
- Blood in urine
- Incontinence of urine

Genitoreproductive - female
- Vaginal discharge
- Heavy period
- Date of last period_____

Genitoreproductive - male
- Discharge form penis
- Testicular pain
- Testicular lump

Subhash Gupta, MD / Mrinal Garg, MD
601 E. Sample Road, Suite 105
Pompano Beach, Florida 33064

**AUTHORIATION FOR USE AND DISCLORSURE OF PROTECTED HEALTH INFORMATION (PHI)**

PATIENT NAME:_____DATE OF BIRTH:_____

I authorize Dr. Subhash Gupta or Dr. Mrinal Garg to use or disclose (as applicable) all of the following medical information (Mark X over information we may not disclose).

| | | |
|---|---|---|
| Consultation Reports | Progress Notes | Operative/Procedure |
| History and Physical | Images | Reports |
| Reports | Radiology Reports | Lab(s) Reports |
| Mental Health | Substance Abuse | Research Records |
| Records | Reports | HIV Results/Testing |

Other (specify)_____

Please indicate date range for treatment and release_____

*Note: Authorizing the release of one or more of these items may include records which did not originate at this office but have been incorporated into the patient record now in the possession of this office.

I DO authorize you to share information with:

Name and relationship _____

---

- I understand that Dr. Subhash Gupta or Dr. Mrinal Garg will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.
- I understand that I may revoke this authorization by sending a written request for revocation to this office.
- I understand that when information is disclosed on my behalf pursuant to this authorization for release the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand that there may be a free associated with the release of my medical information
- I understand that this authorization will not expire unless I request a revocation in writing.

_____ _____

**Signature of Patient** **Date**

_____ _____

Signature of Authorized Representative

Signature of Relationship to Patient
(must provide legal authority)

Subhash Gupta, MD / Mrinal Garg, MD
601 E. Sample Road, Suite 105
Pompano Beach, Florida 33064

# NOTICE OF PRIVACY PRACTICES

This notice applies to this office. This Notice describes how medical information about you may be used and disclosed and you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request. Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information. How We Use Your Patient Health Information We use health information about you for treatment to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission. Examples of Treatment, Payment, and Health Care Operations Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members or your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose this information to other health care providers who are or may be participating in your treatment, to pharmacists or pharmacy personnel who are filling your prescription and to family members, significant other, health aid(s) or surrogates who are helping with your care. Payment: We will use and disclose your health information for payment purpose. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclosed your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it. Special Uses We may use your information to contact you with appointment reminders via phone, fax, email, postcard or letter. We may also contact your to provide information about treatment alternatives or other health related benefits and services that may be of interest you you. Other Uses and Disclosures We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by Law, We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries or events. Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for governments programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding death to coroners, medical examiners, funeral directors and organ donation agencies. Ser Serious threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation we may ask for your written authorization before using or disclosing any identifiable health inflation about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosure of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record for as long as we maintain that information. This designated record includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in your records we received about you are not available for your inspection or copying by law. We may charge you a fee for the cost of copying, mailing or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Contact Person. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must information you of this delay.

Amend Information: If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting Disclosures: You may request a list or instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in affect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the Office Manager.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the Office Manager. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filling a complaint.

Effective Date: December 1, 2008

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

**Signature**: _____

**Print Name**: _____

**Date**:_____

Relation to patient:

_____*Please provide legal validation of right to accept on behalf of the patient

# Gastroenterology

Dr. Subhash Gupta / Dr. Mrinal Garg

601 E Sample Rd., Suite 105

Pompano Beach FL 33064

I _____ Hereby,

Understand that if my insurance **DOES NOT** pay for my visits to the doctor, ultrasounds, procedures done in the office, and/or surgical procedures, then I will be held responsible for the billed amount.

_____

Patient's Signature

_____

Date