Patient Demographic Form
Office visit co-payments are due prior to service.

Sanjeev Gupta, MD
31 Hospital Drive, Massena, NY 13662
315-769-1099

Today's date:	PCP:

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State:	ZIP Code:

Home Phone: ( )	Cell Phone: ( )	Alternate Phone: ( )	Social Security #:

e-mail address:	Parent's Employer:	Employer phone : ( )

Pharmacy name:	Pharmacy phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Is this person a patient here? ❑ Yes ❑ No

Employer:	Occupation:	Employer address:	Employer phone : ( )

Please indicate **primary** insurance	❑ Medicare	❑ Medicaid	❑ Blue Cross Blue Shield	❑ MVP	❑UMR
❑ Empire	❑ Fidelis	❑ United Healthcare	❑ Workers Compensation	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Child	❑ Dependent	❑ Self	❑ Step-child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Child	❑ Dependent	❑ Self	❑ Step-child	❑Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sanjeev Gupta, M.D. or insurance company to release any information required to process my claims. I also understand and agree that privileged information to be released may include any records relating to alcohol abuse, drug abuse, AIDS, HIV, venereal disease, sexual or child abuse, and mental disorders. This authorization will remain in effect until expressly revoked in writing.

Patient/Guardian signature *Date*

Continued on next page

Please assist us by providing the information requested below.

The following persons have my permission to discuss treatment regarding this patient.	1.	2.	3.

The following information is for government reporting purposes only:
Race:

❑African American-Non-Hispanic ❑American Indian/ Alaskan Native ❑Hispanic ❑Asian/Pacific Islander ❑White-Non-Hispanic ❑Other

Ethnicity:

❑African American/Black ❑American Indian ❑Asian ❑Hispanic ❑Pacific Islander ❑Caucasian /White ❑Other

Language:

❑English ❑Spanish ❑Japanese ❑French ❑Other

Release Authorization:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of an original.

Patient/Guardian signature *Date*

Assignment of Benefit:

I hereby authorize Dr. Sanjeev Gupta to apply for benefits on my behalf for covered services rendered by himself, or by his order. I request that my payment from my insurance company be made directly to Dr. Sanjeev Gupta.
I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked at any time by either my insurance company or myself or in writing.

Patient/Guardian signature *Date*

Guarantee of Account:

In case of default payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding balances.
***In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Patient/Guardian signature *Date*

Sanjeev Gupta, MD

31 Hospital Drive

Massena NY 13662

PEDIATRIC HISTORY QUESTIONAIRE

Date Completed: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Do you or your child have any specific communication requirements such as Hearing, Vision or Cognition? YES/ NO If you answered yes, please specify: _____

Contact information for Parent 1

Name: _____ Email: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact information for parent 2

Name: _____ Email: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Child lives with: _____

Hospital where Born: _____ Newborn Screening# _____

Birth weight : _____ Birth Length: _____ Adopted: Yes / No Foster Care: Yes / No

Please circle your response:

Was the delivery vaginal or cesarean?	Vaginal	Cesarean
Was the baby full term?	No	Yes
Did the baby have any problems in the nursery?	No	Yes
Did the baby have any problems during the first month of life?	No	Yes

At what age did your child :

Sit up without Support _____Months

Walk alone _____Months

Talk (putting two words together) _____Months

Become bladder trained _____Months

Become bowel trained _____Months

If in school, present grade _____Grade

Is your child doing well in school? Yes / No

Are there any problems or concerns? _____

_____

PAST MEDICAL HISTORY/HOSPITALIZATIONS/ER VISITS/SURGERIES

Date	Child's Age	Name of Hospital	Reason for Hospitalization/ER/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have Allergies? Yes / No If yes, please list:

_____

Is your child currently taking any medications? Yes / No if yes, please list:

_____

SOCIAL HISTORY

What does the child do in his/ her spare time? _____

How many hours in a day does the child watch TV? _____

Please indicate any financial, interpersonal, or family problems you are worried about:

_____

How does the child do in school? _____

Does your child have good friends? _____

Does anyone in your home smoke? _____

Have any of your children died? _____

Are you currently homeless or displaced? Yes / No If yes, would you like a list of resources to help you? Yes / No

REVIEW OF SYSTEMS

Indicate which of the following conditions this child has ever had:

Skin trouble
Eye problems
Difficulty hearing
Frequent nose bleeds
Pneumonia
Asthma
Heart murmur
Jaundice
Frequent abdominal pain
Removal of tonsils

Frequent constipation
Black stool
Kidney or bladder infection
Painful urination
Anemia
Joint aches or pain
Loss of consciousness
Seizures
Frequent Headaches
Frequent diarrhea

Removal of adenoids
Behavioral problems
Rheumatic fever
Measles
Chicken Pox
Mumps
Rubella
Broken bones
Tubes in ears
Other:_____

FAMILY HISTORY

Indicate any of the following diseases that relatives (parent, grandparent, siblings,) have:

Arthritis_____
HIV/AIDS_____
Eczema_____
Seizure disorder_____
Tuberculosis_____
Hay fever_____
Asthma_____
High Blood pressure_____
Heart attack_____
Diabetes_____
Obesity_____

Anemia or Blood problems_____
Alcoholism_____
Kidney Disease_____
Cystic Fibrosis_____
Cancers_____
Mentally Handicapped_____
Birth Defects_____
Psychiatric problems_____
Stroke_____
Death before 50 years of age_____
High Cholesterol_____

REVIEWED BY: _____Date: _____

Doctor's Signature

NEW YORK STATE IMMUNIZATION REGISTRY
PARENTAL CONSENT FORM

We are participating in the Central New York Immunization Registry (CNYIR) which is part of the New York State Immunization Registry. CNYIR maintains the immunization and lead records for children living in the Central New York area and makes them quickly available when they are needed. Your child's computerized records are kept private and confidential.

To have your child's immunization records included in the New York State Immunization Registry, please sign the consent below.

I consent to my child's immunization information and identifying demographic information being placed in the New York State Immunization Registry to assist in my child's medical care and treatment. The immunization information may be released to: the patient if over 18 years of age, the parent or legal guardian of a minor, their insurance company, school or licensed daycare, the local and state health department or to a medical provider authorized to provide medical care for my child. I understand that I can withdraw from the Registry at any time with notification to my child's primary care provider.

I understand my child's lead records will be shared by the Central New York Immunization Registry.

_____ _____

Child's Name **Date of Birth**

_____ _____

Parent or Guardian Signature **Relationship**

The following information is necessary to uniquely identify your child and match his/her immunization to his/her birth information in the New York State Immunization Registry.

Mother's Information

First Name:_____

Maiden Name:_____

Date of Birth:_____

Last 4 digits of Social Security Number:_____

Child's Information

County/State of Birth:_____

Birthdate:_____

Birth Order:_____

(If single birth use 1, if multiple birth use 1 for first born, 2 for second born etc.)

Sanjeev Gupta MD and Mukta Gupta MD

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).
☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Sanjeev Gupta and Dr. Mukta Gupta reserves the right to modify the privacy practices as outlined in the notice

I have received a copy of the Notice of Privacy Practices for Dr. Sanjeev Gupta and Dr. Mukta Gupta

Name of Patient: _____

Signature of Patient: _____

Today's date: _____

Signature of Patient Representative: _____

(Required if the patient is a minor or an adult who is unable to sign)

Relationship of Patient Representative to the Patient: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
WE DO NOT ACCEPT CD'S OF RECORDS

PATIENT NAME:_____ DATE OF BIRTH:_____
ADDRESS:_____
PHONE NUMBER:_____ SS#_____

I HERBY AUTHORIZE DR._____ TO RELEASE PERSONAL HEALTH INFORMATION FROM THE MEDICAL RECORDS OF THE ABOVE NAMED PATIENT.

ADDRESS OF DR.:_____
PHONE:_____ FAX:_____

TO: DR. SANJEEV GUPTA
31 HOSPITAL DR.
MASSENA NY 13662
PHONE: (315) 769-1099 FAX: (315) 705-4969

FOR THE FOLLOWING PURPOSE:_____

FOR THE FOLLOWING DATES OF SERVICE:_____

TYPE OF RECORDS TO BE RELEASED:

__COPIES OF RECORD __OPERATIVE REPORT __PATHOLOGY REPORT
__EMERGENCY ROOM VISIT __LABS __HISTORY & PHYSICAL
__EKG __CONSULTATIONS __DISCHARGE SUMMARY
__OTHER_____

THIS AUTHORIZATION EXPIRED IN 90 DAYS UNLESS OTHERWISE SPECIFIED. _____

I, _____, HAVE READ THE ABOVE AND AUTHORIZE THE STAFF OF THE DISCLOSING FACILITY NAMED, TO DISCLOSE INFORMATION HEREIN CONTAINED. I UNDERSTAND THAT THIS AUTHORIZATION MAY BE WITHDRAWN BY ME BY NOTIFYING MY PROVIDER IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON IT. THE PROVIDER IS RELEASED AND HARMLESS, COMPLYING WITH THIS AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS.

DATE:_____ SIGNATURE:_____
RELATIONSHIP TO PATIENT:_____

DATE:_____ WITNESS SIGNATURE:_____