Patient Demographic Form

Office visit co-payments are due prior to service.

Mukta 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: 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*

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information on this form to the best of your ability. Thank you.

Today's Date _____

Patient Name:_____DOB_____ AGE_____

- ☐ Do you have any specific communication requirements?
- ☐ Hearing
- ☐ Vision
- ☐ Cognition

HISTORY OF PAST MEDICAL PROBLEMS (CHECK ALL WHICH APPLY)

___ High blood pressure

___Diabetes

___High Cholesterol

___Heart Problems

___Rheumatic Fever

___Arrhythmia

___Atrial Fibrillation

___COPD/Emphysema

___Asthma

___Chronic Bronchitis

___Recurrent Pneumonia

___Back Problems

___Hernia

___Colon Polyps

___Stomach Bleed

___Stomach Ulcers

___Gastritis/ Esophagi is

___Liver Problems

___Hemorrhoids

___Kidney Problems

___Bladder Problems

___Seizure/ Epilepsy

___Stroke

___Migraine

___Carotid Occlusion

___Bleeding Disorders

___Thyroid problems

___Chronic Sinusitis

___Cataract/ Glaucoma

___Arthritis/ Gout

___Muscular Problems

___Deep Vein Thrombosis

___Swelling feet/ Edema

___Peripheral Vascular Disease

___Psychiatric Issues

___Ear/Nose/Throat Problems

___Breast Lump

___Any Cancers

Other Diseases_____

PAST SURGERIES: _____

_____

IMMUNIZATIONS: ____FLU SHOT ___PNEUMONIA SHOT ___TETANUS SHOT ___SHINGLES SHOT

OTHER VACCINES_____

DRUG ALLERGIES: _____

PAST HOSPITALIZATIONS/SERIOUS ILLNESS: _____

_____

Social History:

Tobacco use? YES/NO If Yes, how much do you smoke per day?_____

Past smoker? YES/NO How many packs per day?_____What year did you quit using tobacco?_____

Alcohol Use? YES/NO How many drinks per week?_____ For how long?_____

Drug Use? YES/NO Type and Frequency_____

Marital Status ___Married ___Single ___Divorced ___Separated ____Widowed

Job description_____

Are you in need of transportation to attend your appointments? YES/NO

Are you currently homeless or displaced? YES/NO

Do you have an Advanced Care Plan or Health Care Proxy? YES/ NO Would you like us to assist you with end of life care planning? YES/ NO

Sexual History:

History of Sexually Transmitted diseases? YES/NO_____ If yes, which one(s)?_____

Do you use condoms for protection against STD infection? YES/ NO

FEMALE HISTORY:

Age at which you started your period?___ Date of last period?___How many days does your period last?___Is there any spotting between periods? YES/NO

Do you use birth control? YES/ NO Are you pregnant? YES/NO Number of births/deliveries___Live Births____Miscarriages__

Achieved of menopause? YES/NO If yes, at what age?____ Date of past PAP smear

Do you do monthly breast exams? YES/NO History of breast lumps? YES/NO Date of last mammogram_____

FAMILY HISTORY	**AGE**	**ALIVE**	**DECEASED AT AGE OF**
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____

HISTORY OF FAMILY DISEASES: PLEASE CIRCLE THOSE WHICH APPLY:

HEART DISEASE / HIGH CHOLESTEROL / HYPERTENSION / DIABETES / CANCERS / STROKE / GOUT / THYROID PROBLEMS / SEIZURES / ASTMA / COLON POLYPS / MENTAL HEALTH / SUBSTANCE ABUSE

REVIEW OF SYSTEMS: PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THESE IN THE PAST ONE YEAR

GENERAL

CHILLS/ FEVER

DEPRESSION

DIZZINESS/ FAINTING

HEADACHE

WEIGHT LOSS/LOSS OF SLEEP

NIGHT SWEATS

CARDIAC

CHEST PAIN

HIGH BLOOD PRESSURE

POOR CIRCULATION

SWELLING/NUMBNESS IN FEET

FAST/ SLOW HEARTBEAT

PULMONARY

COUGH

SHORTNESS OF BREATH

WHEEZING/ ASTHMA ATTACK

SPITTING UP BLOOD

PSYCHIATRIC

ANXIETY/ DEPRESSION

SCHIZOPHRENIA

PTSD

GASTROENTEROLOGY

POOR APPETITE/ INDEGESTION

CHANGE IN BOWEL HABITS

CONSTIPATION/DIARRHEA

GAS/BLOATING

RECTAL BLEEDING

NAUSEA/ VOMITING

VOMITING BLOOD

STOMACH PAIN

HEMORRHOIDS

RENAL/G.U.

BLOOD IN URINE

FREQUENT URINATION

POOR BLADDER CONTROL

NEUROLOGICAL

LOSS OF CONSCIOUSNESS

SEIZURES/PARALYSIS

ENDOCRINE

HEAT OR COLD TOLERANCE

EXCESSIVE HUNGER/THIRST

EXCESSIVE URINATION

INCREASED FRY SKIN

DIFFICULTY URINATING

MUSCLE/JOINT/BONE

CHRONIC BACK PAIN

JOINT SWELLING

KNEE HIP/ SHOULDER PAIN

VARICOSE VEINS

HEMATOLOGY/ONCOLOGY

BLEEDING DISORDER

CANCERS

TRANSFUSION

ENT/EYES

BLURRED/ DOUBLE VISION

EAR ACHE/ DISCHARGE

ALLERGIES/ HAY FEVER

HEARING/ VISION LOSS

NOSE BLEEDS

SINUS PROBLEMS

SWOLLEN GLANDS

MEN ONLY

ERECTILE DIFFICULTY

LUMP IN TESTICLES

PENILE DISCHARGE

SIGNATURE OF PATIENT _____ **DATE** _____

SIGNATURE OF DOCTOR _____ **DATE** _____

Patient Health Questionnaire—PHQ-9

Name_____Date of Birth_____Today's Date_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**
	Column Totals:			
Scoring for use by medical or behavioral health professional only:	**Total Score (Sum of all columns)**			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very difficult**
- ☐ **Extremely difficult**

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (valium)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

I	II	III	IV
0	1-2	3-5	6+

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. MUKTA 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:_____

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: _____

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____

Relationship: _____ _____

Contact information: _____

Name: _____

Relationship: _____ _____

Contact information: _____

Contact information: _____ _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate): Mental health records Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment Other (please specify): _____ __

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee): An electronic record or access through an online portal Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

_____ _____