Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian | Date

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

Date symptoms started _____

Have you lost any days from work or school? ☐ Yes ☐ No

Do you have any:

- ☐ Lower Back or Side Pain
- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Difficulty Maintaining an Erection
- ☐ Painful Intercourse
- ☐ Excessively Frequent Urination
- ☐ Inability to Urinate
- ☐ Loss of Bladder Control/ Urinary Incontinence
- ☐ Loss of Bowel Control/ Fecal Incontinence
- ☐ Vaginal Discharge
- ☐ Loss of Urine when Coughing, Sneezing, Bearing Down, Changing Position
- ☐ Waking up at Night to Urinate
  # of times _____
- ☐ Pain with Urination

Medications

What medications are you currently taking? (Include aspirin, other blood thinners, vitamins, minerals, birth control pills, hormones, herbals, supplements)

Name	Dosage	Frequency

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Cancer Type _____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ None of the Above
- ☐ Not Sure

Details: _____

_____

Allergies

Are you allergic to any of the following?

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Seizure Medicines
- ☐ Sulfa

Details/Reactions:

_____

_____

Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Anxiety
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Brain Tumor
- ☐ Hydrocephalus
- ☐ Cancer Type _____
- ☐ Chronic Fatigue
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Bladder Infections
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Neurological Disorder
- ☐ Parasites
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Pelvic Prolapse
- ☐ Renal Failure
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other: _____

For Men:

- ☐ Circumcision
- ☐ Elevated PSA
- ☐ Enlarged prostate (BPH)
- ☐ Erectile Dysfunction
- ☐ Hypogonadism (Low Testosterone)
- ☐ Decreased Libido
- ☐ Premature Ejaculation
- ☐ Prostate Biopsy
- ☐ Prostatectomy
- ☐ Vasectomy

For Women:

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Number of Vaginal Deliveries: _____

Date of Last Menstrual Period: _____

Hysterectomy: ☐ Yes ☐ No

Type of contraception used:

- ☐ Condoms
- ☐ Pills
- ☐ Patch
- ☐ Ring
- ☐ Shot
- ☐ Device under skin
- ☐ IUD
- ☐ Vasectomy
- ☐ Tubal ligation
- ☐ Not applicable

Hospitalizations & Surgeries

Reason	Date

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use chewing tobacco?

☐ Yes ☐ No

Are you exposed to second hand smoke?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No type(s)? _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

(include soda, tea, cofffee, hot chocolate, RedBull, etc.)

drinks/day _____

Are you sexually active?

☐ Yes ☐ No

How many partners within the past year?

_____

How would you identify your sexual orientation?

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Asexual

☐ Transsexual ☐ Other ☐ Unsure/Questioning ☐ Prefer Not to Answer

Do you wish to be checked for sexually transmitted infections?

☐ Yes ☐ No

How often do you exercise?

times/week _____

Patient's Hobbies:

_____

_____

Review of Systems

General

- ☐ Excessive Thirst
- ☐ Fever
- ☐ Night Sweats
- ☐ Heat or Cold Sensitivity
- ☐ Weight Gain
- ☐ Weight Loss

Gastrointestinal

- ☐ Abdominal Cramps/Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Skin

- ☐ Easy Bruising
- ☐ Excessive Dry Skin
- ☐ Excessive Hair Growth
- ☐ New Stretch Marks
- ☐ Skin Discoloration

Musculoskeletal

- ☐ Back Pain
- ☐ Fracture
- ☐ Joint Stiffness
- ☐ Joint Pain
- ☐ Muscle Cramping

Neuro/Psychological

- ☐ Anxiety
- ☐ Burning pain in feet
- ☐ Depression
- ☐ Frequent Headache
- ☐ Fainting
- ☐ Memory Loss
- ☐ Numbness
- ☐ Seizures
- ☐ Sleeping Problems
- ☐ Suicidal Thoughts
- ☐ Tremor

Ear, Nose & Throat

- ☐ Hoarseness
- ☐ Sinus Congestion

Eye

- ☐ Blurry Vision
- ☐ Bulging Eyes
- ☐ Double Vision
- ☐ Visual Loss

Respiratory

- ☐ Coughing
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiology

- ☐ Chest Pain
- ☐ Lightheadedness
- ☐ Leg Swelling
- ☐ Palpitations

Tests/Procedures

	Date Last Performed
☐ Abdominal/Pelvic CT	_____
☐ Cystoscopy	_____
☐ Kidney and Bladder Ultrasound	_____
☐ KUB (X-Ray of Kidneys)	_____
☐ Prostate Biopsy	_____
☐ PSA	_____
☐ Urodynamic Studies	_____

Sanjeev Gupta, 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. Sanjeev Gupta 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. Sanjeev Gupta 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)

Sanjeev Gupta, 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.

UROLOGY
MEDICAL SPECIALISTS

Sanjeev K. Gupta, M.D.
Board Certified Urology
"Adult and Pediatric Urological Care"

ATTENTION ALL PATIENTS

Our office would like to inform you that if you have any testing or procedures done in the office or outside of the office performed or ordered by your physician, that it is patient responsibility to make a follow up visit in office to obtain your results.

If you contact our office and are unable to get through, we apologize in advance and ask you to please contact your physician via text message if an urgent answer is needed.

Dr. Sanjeev Gupta (319)621-5796

Please be aware that depending on the test/procedure you may not be able to obtain these results over the phone.

Testing/Procedures include the following:

- Biopsies
- Blood Draws/Labs
- CT/CT Pet Scans
- Cystoscopies
- MRI's
- X-rays
- Ultrasounds

Thank you for your patience and understanding.

Patient Signature _____ Date_____

Urology Medical Specialist

Dr. Sanjeev Gupta

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