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Raphael Ga	bav Do
Neil Gottlie	h MD
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PATIENT REGISTRATION

PATIENT NAME (LAST)		(FIRST)		(MI)	_	TODAYS	DATE:		
(#/S 7	TREET)		(CITY)				(STATE)	(ZIP)	
SOCIAL SEC #				DAT	E OF BI	RTH			
HOME PHONE # ()		WORK	PHONE #				EXT	
CELL PHONE # ()		OTHER	PHONE/E	MAIL:				
SEX MALE F	EMALE			MARITA	L STATU	S □ SINGL	E 🗆 MARR	IED OTHER	
RACE CAUCASION	AFRICAN AMERICAN.	HISPANIC OTHE	R	RELIGIO	N (OPTIC	ONAL):			
EMPLOYER'S NAME:				EMPLOY	ERS PH	ONE#			1
PRIMARY CARE PHYSICIA	AN:		_	PHYSIC	AN'S PH	ONE NUME	BER:		_
IF THE PATIENT IS A MINO	OR, PARENT/GUARDIAN: _			TELEPH	OŅE	<u></u>)		
INSURANCE INFORMA	TION					(t = 0)			
PRIMARY INSURANCE			- .	TELEPH	ONE)		
IDENTIFICATION#		·		GROUP/	PLAN#				
ADDRESS			·						
RELATION TO INSURED	SELF	□ SPOUSE	□ сніі	.D		ER			
IF OTHER THAN SELF:	NAME OF INSURED		_	D.O.B.			SSN#		
SECONDARY INSURANCE	I		_	TELEPH	ONE	()			
IDENTIFICATION #				GROUP/	PLAN#				
ADDRESS						··			
RELATION TO INSURED	☐ SELF	☐ SPOUSE	☐ CHIL	.D	☐ OTHE	ER			
F OTHER THAN SELF:	NAME OF INSURED		_	D.O.B.			SSN#		
ACCIDENT INFORMATIO	ON (if applicable)		all set	4.4			A WEST		
ARE YOU SEEING THE DO	CTÓR BECAUSE OF AN AC	CIDENT? YES*	□ NO	DATE OF	ACCIDE	:NT:		1	
TYPE OF ACCIDENT:	MOTOR VEHICLE ACCIDENT	□ WORKERS' COM	/PENSATI	ON** □	OTHER				
NSURANCE COMPANY:			_	TELEPHO	ONE	()	<u> </u>	
CLAIM#		ADJUST	ER'S NAM	1E					
DDRESS									
IF THERE AN ATT	ORNEY INVOLVED IN YOU	R CASE, PLEASE PR	OVIDE:						
NAME:			_TELEPH	ONE)	_ -		

טטו טע	HAVE A LIVING WILL OR ADVANCE	DIRECTIVE?	YES D NO	
ieduni:	istory			
Reason	or your visit?			
List any	prescription medications, over the	counter medication	s including herbals and vit	tamins?.
Are vou	Allergic to any medications foods	havfever other?		
Do voits	smoke/chew tohacco?	How much?	How lorg?	
Do you o	drink alcohol?	How much?	How often?	
Have you	Allergic to any medications, foods, smoke/chew tobacco?drink alcohol?u had any previous surgery?(what leads any previous surgery?)	and date)	TIOW OILENS	
Are there	e any illnesses that run in your imm	ediate family? (who	et who)	
740 4101			WING MEDICAL PROBL	EMS
		Yes No		Yes No
		Y		
	Heart Disease		Liver Problems	
	High Blood Pressure		Respiratory Problems	
	Diabetes		Arthritis	
	Thyroid Problems		Seizures or Epilepsy	
	High Cholesterol		Blood Disorders	
	Rheumatic Fever	 	Cancer	
i	Heart Murmurs		Anesthesia Problems	- - -
j	Stomach Problems		Other	- - -
******Insu	rance/Referral Waiver:		O trioi	
	ot bring a referral for the medical se	rvices that I will rec	eive todav. If my primary o	care physician does not
provide a	referral within TWO days of this vis	it, I understand that	I will be responsible for pa	aying for the services I
received a	and requested today.		•	
Signature	of Patient/Legal Guardian:X			Date:
C lundon	atand that in the arrant of tamein at	f.b		
all corvice	stand that in the event of terminations	n of benefits and/o	r lack of insurance, that I a	m financially responsible for
all SCI AICE			hav ENT will not be veene	aible for our for our interest
accrued	s rendered, and Gabay, Gottneb, &	Assoc. PC, &/or Ga	bay ENT will not be respon	sible for any financial cost
accrued.		Assoc. PC, &/or Gal		
accrued. Signature	of Patient/Legal Guardian:X			Date:
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