Raphael Gabay, DO
Neil Gottlieb, MD

# PATIENT REGISTRATION

PATIENT NAME _____ TODAYS DATE: _____
(LAST) (FIRST) (MI)

ADDRESS _____
(#/STREET) (CITY) (STATE) (ZIP)

SOCIAL SEC # ___ - ___ - ___ DATE OF BIRTH ___/___/___

HOME PHONE # (___) _____ WORK PHONE # (___) _____ EXT _____

CELL PHONE # (___) _____ OTHER PHONE/EMAIL: _____

SEX ☐ MALE ☐ FEMALE MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER

RACE ☐ CAUCASION ☐ AFRICAN AMERICAN. ☐ HISPANIC ☐ OTHER RELIGION *(OPTIONAL)*: _____

EMPLOYER'S NAME: _____ EMPLOYERS PHONE# _____

PRIMARY CARE PHYSICIAN: _____ PHYSICIAN'S PHONE NUMBER: _____

IF THE PATIENT IS A MINOR, PARENT/GUARDIAN: _____ TELEPHONE (___) _____

## INSURANCE INFORMATION

PRIMARY INSURANCE _____ TELEPHONE (___) _____

IDENTIFICATION # _____ GROUP/PLAN # _____

ADDRESS _____

RELATION TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IF OTHER THAN SELF: NAME OF INSURED _____ D.O.B. ___/___/___ SSN# ___ - ___ - ___

SECONDARY INSURANCE _____ TELEPHONE ( ) _____

IDENTIFICATION # _____ GROUP/PLAN # _____

ADDRESS _____

RELATION TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IF OTHER THAN SELF: NAME OF INSURED _____ D.O.B. ___/___/___ SSN# ___ - ___ - ___

## ACCIDENT INFORMATION *(if applicable)*

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? ☐ YES* ☐ NO DATE OF ACCIDENT: ___/___/___

TYPE OF ACCIDENT: ☐ MOTOR VEHICLE ACCIDENT ☐ WORKERS' COMPENSATION** ☐ OTHER _____

INSURANCE COMPANY: _____ TELEPHONE (___) ___ - _____

CLAIM# _____ ADJUSTER'S NAME _____

ADDRESS _____

- IF THERE AN ATTORNEY INVOLVED IN YOUR CASE, PLEASE PROVIDE:

NAME: _____ TELEPHONE (___) ___ - _____

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE? ☐ YES ☐ NO

**Health History**

Reason for your visit?_____

List any prescription medications, over the counter medications including herbals and vitamins?.

_____

Are you Allergic to any medications, foods, hayfever, other? _____

Do you smoke/chew tobacco?_____ How much?_____ How long?_____

Do you drink alcohol?_____ How much?_____ How often?_____

Have you had any previous surgery?(what kind, date)_____

Are there any illnesses that run in your immediate family? (what, who)_____

**DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS**

| | Yes ✓ | No ✓ | | Yes ✓ | No ✓ |
|---|---|---|---|---|---|
| Heart Disease | | | Liver Problems | | |
| High Blood Pressure | | | Respiratory Problems | | |
| Diabetes | | | Arthritis | | |
| Thyroid Problems | | | Seizures or Epilepsy | | |
| High Cholesterol | | | Blood Disorders | | |
| Rheumatic Fever | | | Cancer | | |
| Heart Murmurs | | | Anesthesia Problems | | |
| Stomach Problems | | | Other | | |

******Insurance/Referral Waiver:**

☐ **I did not bring a referral for the medical services that I will receive today. If my primary care physician does not provide a referral within TWO days of this visit, I understand that I will be responsible for paying for the services I received and requested today.**

**Signature of Patient/Legal Guardian:X**_____ **Date:**_____

☐ **I understand that in the event of termination of benefits and/or lack of insurance, that I am financially responsible for all services rendered, and Gabay, Gottlieb, & Assoc. PC, &/or Gabay ENT will not be responsible for any financial cost accrued.**

**Signature of Patient/Legal Guardian:X**_____ **Date:**_____

**THE FOLLOWING IS FOR THE RELEASE OF MEDICAL INFORMATION TO YOUR INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS TO OUR FACILITY**

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to: Gabay, ENT & Associates or Gabay, Gottlieb and Assoc. PC. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

**Signature of Patient or Guardian X** _____ **Date** _____

**FOR PATIENTS WITH MEDICARE INSURANCE (IN ADDITION TO THE ABOVE)**

Are you or your spouse retired from the military and have military health benefits? ___(if yes) Have you applied for *Tricare*?____

Is this patient covered by any Employer Group Health Plan (EGHP) including Federal Employee Benefits?_____

Is this patient or the patient's spouse actively employed by an employer of 20 or more employees?_____

Is this patient entitled to Medicare coverage solely on the basis of disability?_____

I request that payment of authorized Medicare benefits be made to Gabay, ENT & Associates or Gabay, Gottlieb, and Assoc. PC for services furnished to me by the facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services

**Beneficiary Signature X** _____ **Date** ____/____/____

**FOR PATIENTS WITH MEDICARE & SECONDARY (SUPPLEMENTAL) INSURANCE (IN ADDITION TO BOTH ABOVE)**

I hereby give Gabay, ENT & Associates or Gabay, Gottlieb, and Assoc. PC permission to ask for Medicare Supplemental Insurance payments for my medical care and I understand that my Secondary Insurance Carrier needs information about me and my medical condition to make a decision about these payments. I request that payment of authorized Medicare Supplemental benefits be made to Gabay, ENT & Associates or Gabay, Gottlieb & Assoc. PC for any services furnished to me by the facility.

**Beneficiary Signature X** _____ **Date** ____/____/____