Gastroenterology of Greater Orlando

Vishal Gupta M.D.
Raul Badillo M.D.
Ashil Gosalia M.D.
Board Certified in Gastroenterology

NEW PATIENT REGISTRATION FORM

Last Name		First Name		MI	
Date of Birth (mm/dd/yyyy)		Today's Date			
Address					
City		State		Zip	
Email					
Home Phone		Cell Phone			
Work Phone		Other Phone			
Gender	M / F / Trans / Other	Social Security #		Marital Status	Married / Single / Widowed / Divorced
Who referred you to our practice?					
Primary Care Physician					

EMERGENCY CONTACT

Name		Phone #		Relationship	
Address					

INSURANCE INFORMATION

Primary Insurance Company		Secondary Insurance	

Person who is responsible for Insurance Account
(Person who holds the insurance policy or legal guardian of a minor. If you are the holder, you may skip this part)

Last Name		First Name		MI	
Home Phone		Cell Phone			
Work Phone		Other Phone			
Relationship to Patient		Social Security #			
Date of Birth (mm/dd/yyyy)		Gender	Male / Female / Trans / Other		
Employer		Occupation			

2884 Wellness Ave
Orange City, FL 32763
(386) 668-2221

860 Peachwood Dr
DeLand, FL 32720
(386) 469-7993

1319 S International Pkwy, Ste 1171
Lake Mary, FL 32746
(407) 749-6656

Gastroenterology of Greater Orlando

Vishal Gupta M.D.
Raul Badillo M.D.
Ashil Gosalia M.D.
Board Certified in Gastroenterology

Name		**Date**	
Reason for Visit			

Current Medications		**Past Medical History (check all that apply)**
		High Blood Pressure
		Strokes
		Diabetes
		High Cholesterol
		Heart Disease → Details:
Allergies to Medications		Angina
		Congestive Heart Failure
		Emphysema / Smoker's Lung
		Asthma
Social History		Prostate Problems → Cancer / Enlarged
Have you ever smoked? Y N		Thyroid Problems → Hypothyroidism / Hyperthyroidism
Do you currently smoke? Y N		Seizures
If yes how much? →		Cancer
Do you drink alcohol? Y N		Depression
If yes, how much? →		Arthritis
Any history of Illicit Drugs? Y N		Kidney Disease
Family History (check all that apply)		Other → Details:

	Heart Disease		Colon Cancer	**Past Surgical History (check all that apply)**
	Diabetes		Colon Polyps	Heart Catheterization
	High Blood Pressure		Crohn's Disease	Open Heart Surgery
	Stroke		Ulcerative Colitis	Appendix Surgery
	Other →			Gallbladder Surgery
Colonoscopy				Other Surgeries → Details:
Year of Latest Colonoscopy				
Year of Latest Upper Endoscopy EGD				

2884 Wellness Ave
Orange City, FL 32763
(386) 668-2221

860 Peachwood Dr
DeLand, FL 32720
(386) 469-7993

1319 S International Pkwy, Ste 1171
Lake Mary, FL 32746
(407) 749-6656

Gastroenterology of Greater Orlando

Vishal Gupta M.D.
Raul Badillo M.D.
Ashil Gosalia M.D.
Board Certified in Gastroenterology

Authorization for Treatment / Release of Information

Consent to Treatment: The patient and/or authorized representative do hereby consent to any and all medical treatment which may deem advisable by the physician(s) of Gastroenterology of Greater Orlando.

Authorization for Release of Confidential Information: I hereby authorize Gastroenterology of Great Orlando to release medical information contained in my/the patient's records to any insurance carrier, employer or other third party intermediary utilized by the patients for the purpose of obtaining information and/or reviewing the record of medical care received by the patient for the payment of all medical charges. Copies of records may also be sent to referring physicians for continuity of care. Medical Records released may include any diagnostic or therapeutic information of visits and/or procedures performed in office. Unless initialed below the records may not include any confidential information regarding

_____*Alcohol/Substance Abuse* | _____*Mental Health* | _____*HIV*

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA):
The patient's medical record may not be furnished to and the medical condition of the patient may not be discussed with any other person than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization. The patient may at this time authorize an individual to be actively involved in the patient's information as mention above.

Name:_____Relationship:_____

Assignment of Insurance Benefits: I assign payment directly to Gastroenterology of Greater Orlando, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment, I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after (30) days. In after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.
Medicare Patients: I certify that the information given by me in applying the payment under title xvii of the Social Act is correct. I authorize Gastroenterology of Greater Orlando to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medicare claim. I hereby authorize payment directly to Gastroenterology of Greater Orlando for medical benefits otherwise payable to me as a beneficiary of the Medical Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routine testing may not be covered by Medicare unless the physician provides medical necessity.
Pre-Authorization: Your insurance company may require pre-authorization for office visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (Primary Care Physician) I will be liable for charges incurred.

Patient/Guarantor Agreement: I understand that Gastroenterology of Greater Orlando is not the business of extending credit. Therefore, it is the policy of Gastroenterology of Greater Orlando to require payment in full at the time of service. If unable to pay patient due balance in full at the time of service, I agree to make prior arrangements with the billing department.

I understand that I am financially responsible for my/the patient's account with Gastroenterology of Greater Orlando, regardless of my insurance benefits. I authorize a copy of this form to be valid as the original.

Patient/Responsible Party:_____Date:_____

Gastroenterology of Greater Orlando

Vishal Gupta M.D.
Raul Badillo M.D.
Ashil Gosalia M.D.
Board Certified in Gastroenterology

Advance Care Plan

(Patients Aged 65 Years or Older)

Name	
Address	
Date of Birth (mm/dd/yyyy)	

If I cannot speak for myself, I would like my doctor to talk about my health care and medical problems to the following person/s: (please write their name and contact number/s):

Name	Phone Number

Signature _____

Printed Name _____

Date _____

2884 Wellness Ave
Orange City, FL 32763
(386) 668-2221

860 Peachwood Dr
DeLand, FL 32720
(386) 469-7993

1319 S International Pkwy, Ste 1171
Lake Mary, FL 32746
(407) 749-6656