ASHA GUPTA MD FAAAAI

BOARD CERTIFIED IN ALLERGY & IMMUNOLOGY

260, RIVERSIDE DRIVE, JOHNSON CITY, NY 13790
PHONE 607-798-7811 FAX 607-770-7035

IMPORTANT INFORMATION ABOUT YOUR APPOINTMENT

PLEASE HELP US SERVE YOU EFFICIENTLY:

- Please fill out and print the PATIENT INFORMATION FORM and the MEDICATION AND ALLERGY LIST and bring them with you to the office on the day of your visit. If you chose to print the form and fill them by hand, please use black ink pen.

- **PLEASE BRING YOUR HEALTH INSURANCE CARD WITH YOU.** We cannot serve you without your insurance card.

- Please try to arrive 10 minutes before your appointment time so we can review you information and prepare your chart

- If your insurance requires referral from your Primary Care Provider, you are responsible for obtaining this referral.

- Not sure if you need a referral? Check with your insurance company or your primary care provider.

- Co-Pays and other applicable payments are due at the time of visit.

- If you do not have health insurance or we do not participate in your plan, you will be responsible for your payment. **We accept Visa and MasterCard.**

- If you need to **cancel the appointment,** please give us **at least 24 hour notice** as we have set aside a full hour for your visit.

- This website explains what you can expect from your appointment. If you still have questions, feel free to call us.

ASHA GUPTA MD — PATIENT INFORMATION

Please Print Legibly & Answer All Applicable Questions

Information About the Patient

Name_____ Date of Birth ____/ ____ / ____
Last name first name middle initial

Address_____
Street or PO Box city state zip code

Home Phone _____Mobil Phone_____Other Phone(family etc.)_____

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Occupation _____ Employer_____ Work Phone_____

Are you a full time college student? ☐Yes ☐ No

Primary Care Physician_____Referring Physician_____

Information About the Person Responsible for Payment of Medical Bills of the Patient

Name_____ Relation to Patient_____ Date of Birth____/ ____ / ____

_____
Address if different from patient's address city state zip code

Employer_____ Work Phone_____

Medical Insurance Information

Insurance Company_____ Policy Number_____

Subscriber's Name_____Relation to patient_____ Date of Birth____/ ____ / ____
(Name of the person who carries the insurance)

Additional / Secondary Insurance Company_____Policy Number_____

Subscriber's Name_____Relation to Patient_____ Date of Birth____/ ____ / ____

Emergency Contact Information

Name _____Relation_____

Home Phone_____Work _____Mobil_____

Consent for Payment and for Release of Information

I certify that the information I have provided above is correct. I authorize Dr. Gupta to release my protected medical information to my insurance company, its agencies and/or Medicare, for the purpose of payment or quality assurance in accordance with the HIPPA policy posted in this office. I authorize Dr. Gupta to collect payment from my insurance company. I understand that I am responsible for payment of charges not covered by my insurance.

Signature_____Print Name if signing for a minor_____ Date____/ ____ / ____

MEDICATION AND ALLERGY LIST

NAME_____ DATE_____

Which pharmacy do you use? _____

LIST ALL MEDICATIONS YOU ARE TAKING

MEDICINE NAME **DOSE AND FREQUENCY**

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LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

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