VERNICK & GOPAL
HEARING CENTER
1244 BOYLSTON ST. SUITE 303
CHESTNUT HILL, MA 02467
Office # 617-383-6830 Fax # 617-383-6880 **SSIMED#**_____

Demographics:

Patient's Last Name: _____ First Name: _____

Social Security # (SSN): _____-_____-_____ Male ☐ Female ☐

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Mobile/Other: Phone: _____ Birthdate: _____/_____/_____

Marital Status: ☐ Married ☐ Divorced ☐ Single **Email:**_____

Health Status: ☐ Hearing Impaired ☐ Visually Impaired ☐ Disabled

Emergency Contact/Nearest Relative Information:

Name: _____

Relationship: Spouse ☐ Brother ☐ Sister ☐ Daughter ☐ Son ☐ Parent ☐ Friend ☐ Other ☐ _____

Telephone or Cell Phone (best way to reach): _____

Referral Information:

Primary Care Physician:

Name:_____

Address: _____

Telephone #: _____

Fax #: _____

Referring Physician:

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

Insurance Information:

Primary Insurance: _____ Membership ID: _____

Group #: _____ Carrier's Name: _____

Carrier's DOB: _____ Relationship to Patient: _____

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Secondary Insurance: _____ Membership ID: _____

Group #: _____ Carrier's Name: _____

Carrier's DOB: _____ Relationship to Patient: _____

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NEW PATIENT REGISTRATION FORM

Name:_____ **DOB:**_____

Primary Care Physician:_____ **Occupation:**_____

I. **Primary Symptom (s):**_____

_____

II. **Present Symptoms and Hearing Complaints:**

Hearing Loss: Both Ears Right Only Left Only N/A

When did your hearing loss first begin?_____

Do you know what caused your hearing loss?_____

Has your hearing changed? (i.e. sudden, gradual, fluctuating)_____

Do you have a better hearing ear?_____

Tinnitus (Noise in ears): Both Ears Right Only Left Only N/A

Describe the sound:_____

When did it first occur?_____

Is the sound constant or periodic?_____

If periodic, how often does it occur?_____

Is the sound distressing to you? If yes, describe:_____

Feeling of Fullness: Both Ears Right Only Left Only N/A

When did the fullness first occur?_____

Constant or periodic?_____

If periodic, how often does it occur?_____

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Dizziness/Unsteadiness: _____ None

Describe the symptom(s):_____

When did it first occur?_____

Constant or periodic?_____

If periodic, how long does it last?_____

Noise History:

Do you have military experience?

YES NO

Have you been exposed to noise in the past 14 hours?

YES NO

If yes, did you wear hearing protection during the entire noise exposure?

YES NO

When in high noise areas, I use hearing protection: 0% 20% 40% 60%

80% 100%

Type of hearing protection used _____

Have you ever participated in any of the following? Circle all that apply.

Chain saw	Dirt bike or loud RV	Firearms	Loud Music
Lawn Equipment	Wood working equipment	Other Noise Exposure_____	

Hearing Aids: Both Ears Right Only Left Only N/A

Make:_____

Model:_____

Style:_____

Year:_____

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Ear Infections/Middle Ear Problems: Both Ears Right Only Left Only N/A

Describe condition(s):_____

Previous treatment(s):_____

III. In the past 90 days have you experienced:

Ear Pain: Both Ears Right Only Left Only N/A

Ear Discharge: Both Ears Right Only Left Only N/A

Sudden Change in Hearing: Both Ears Right Only Left Only N/A

IV. Have you seen a physician or ear specialist in the last six months?

YES NO

Doctor's Names:_____

_____

V. Have you ever had any of the following physical conditions? Circle Yes or No and describe.

Middle Ear Infections_____ YES NO

Ear Surgery_____ YES NO

Ear Malformations_____ YES NO

Vision Loss_____ YES NO

Cleft Palate_____ YES NO

Heart Defect_____ YES NO

Kidney disease or infection_____ YES NO

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Arthritis_____	YES	NO
Diabetes_____	YES	NO
Bones that break easily_____	YES	NO
Learning impairment_____	YES	NO
High blood pressure_____	YES	NO
Head injury/unconsciousness_____	YES	NO
Mumps_____	YES	NO
Scarlet Fever_____	YES	NO
Measles_____	YES	NO
Meningitis_____	YES	NO
Allergies_____	YES	NO
Chemo/Radiation_____	YES	NO

VI. **Family History of Hearing Loss:**_____

_____

_____

VII. **Please list all medications you are currently taking and allergies: (See attached Medication Form)**

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Medication Form

Patient's Name: _____

D.O.B. _____

Date of Service: _____

Drug / Medication Information

List all medications you are currently taking: Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medication/Drug Name	Dose	Frequency	When You Last Took Medication

Please list any known allergies:

_____

_____

_____

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Authorization Information

Assignment of Benefits:

I hereby assign to Vernick and Gopal, LLC, any insurance or other third-party benefits available for health care services provided to me. I, also, understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I, also, understand that in the event that services rendered are not covered under my "insurance"; I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice all payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered at this time.

Signature of Patient or Legal Guardian:_____

Referral Acknowledgement:

I understand that if at any time my insurance plan requires a referral or prior approval and I receive care without it, my insurance plan may not cover my services and I agree to pay all charges. I understand that I am responsible to pay for the services rendered including attorney fees and cost or collection in the event of default.

Signature of Patient or Legal Guardian:_____

Privacy Notice:

I understand that I may request a copy of the Vernick and Gopal, LLC Privacy Notice from the office staff at any time.

Signature of Patient or Legal Guardian:_____

_____ PATIENT INFORMATION_____

*LAST NAME:*_____ *FIRST NAME:*_____

*DATE of BIRTH:*_____ *Date:*_____/_____/_____