Account # _____

David Vernick, MD, FACS
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New Patient Registration

Appointment Date: Appointment With:

Last Name: _____
First Name: _____
SS #: _____
Sex: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Other Phone: _____
Date of Birth: _____
Height: _____ Weight: _____
Single Married Widowed Divorced
Language: _____
Race/Ethnicity: _____
Email: _____

****

Referring Physician

Name: _____
Address: _____
Phone: _____ Fax: _____

Primary Care Physician

Name: _____
Address: _____
Phone: _____ Fax: _____

Primary Insurance: _____
ID #: _____
Group #: _____
Carrier's Name: _____
Carrier DOB: _____
Relationship to patient: _____

****

Secondary Insurance: _____
ID #: _____
Group #: _____
Carrier's Name: _____
Carrier DOB: _____
Relationship to patient: _____

****

Pharmacy

Name: _____
Address: _____
Phone: _____ Fax: _____

Emergency Contact

Name: _____
Relationship: _____
Phone: _____

Vernick & Gopal, LLC Account # _____

Name _____

Date of Birth _____ **Date** _____

Medical History
Please indicate any and all conditions, either past or present.

Are you currently feeling in good health? _____
Have you experienced a recent weight loss? _____

Red, swollen or itchy eyes _____
Hives/rashes _____

Difficulty swallowing _____
Difficulty hearing _____
Noises in ears/head _____
Frequent nosebleeds _____

Wheezing _____
Hay fever _____
Chronic headache _____

Pregnant (present) _____
Breast feeding (present) _____

Abdominal Pain _____
Bowel habit change _____
Heartburn _____

Joint pain or swelling _____
Limited joint movement _____

Anxious _____
Depressed _____

Painful or enlarged glands _____
Bruise easily _____
Keloid scarring _____
Poor wound healing _____
Prolonged bleeding _____

Reason for today's visit: _____

_____

_____

Chronic medical conditions: _____

_____

_____

Anemia
Angina/chest pain
Arthritis
Asthma
Blood clots
Blood transfusion
Cancer
Diabetes
Emphysema
Glaucoma
Head injuries
Heart disease
  Mitral Valve Prolapse
  Heart Murmur
Hepatitis
High blood pressure
High cholesterol
HIV or AIDS
Kidney disease
Liver disease
Pneumonia
Reflux
Seizures
Stomach ulcer
Stroke
Thyroid Disease
Tuberculosis
Other

_____

Medications **Dose/Frequency**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Aspirin _____
Ibuprofen _____
Blood thinners _____

Allergies
Medication/Foods/Seasonal

_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History

Do you smoke? _____
Have you ever smoked? _____
If yes, how many years? _____
Alcohol: drinks/week _____
Recreational drugs _____
Exposure to fumes, solvents, or airborne particles _____

_____
Occupation _____
Marital Status _____
Hobbies _____

Family History

Close relatives diagnosed with any of the following:
Cancer _____
Diabetes _____
Migraines _____
Heart disease _____
Respiratory disease _____
Bleeding disorders _____
Hearing loss _____

Surgeries

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had a tonsillectomy? _____
Date _____

List all MD's to receive notes:

_____
_____
_____
_____
_____
_____
_____

_____
Patient Name

_____
Date of Birth

_____
Patient Signature

_____
Physician Signature

_____
Date