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:____

 Revised 7/2015

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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:*______/________/_______