

Vernick and Gopal, LLC
1244 Boylston St, Suite 303
Chestnut Hill, MA 02467
Tel 617-383-6800 Fax 617-383-6801

Date: _____

Patient Update Form

Acct# _____

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: _____

Emergency Contact: Name: _____ Relationship: _____

Best contact telephone#: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Membership ID# _____ Membership ID# _____

Carrier's Name and DOB: _____ Carrier's Name and DOB: _____

Relationship to patient: _____ Relationship to patient: _____

Referral Information:

Who referred you to our office today? How did you hear about our practice?

Primary Care Physician:

Name: _____ Address: _____

Telephone #: _____ Fax #: _____

Please list names of any ADDITIONAL PHYSICIANS that should receive notes from our office

1. Name: _____ Address: _____

Telephone _____ Specialty: _____

2. Name: _____ Address: _____

Telephone: _____ Specialty: _____

Name: _____ Acct# _____

Date of Birth: _____

Reason for today's visit: _____

Constitutional: Circle yes or no

Are you currently feeling in good health? Yes No

Have you experienced a recent weight loss? Yes No

Have you had a pneumonia immunization? Yes No

Medical History

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

Eyes	_____
Red, swollen or itchy eyes	_____
Ears/Nose, Mouth/Throat	_____
Difficulty swallowing	_____
Difficulty hearing	_____
Noises in ears/head	_____
Frequent nosebleeds	_____
Respiratory	_____
Wheezing	_____
Genitourinary	_____
Pregnant	_____
Breast feeding	_____
Gastrointestinal	_____
Abdominal pain	_____
Bowel habit change	_____
Musculoskeletal	_____
Joint pain or swelling	_____
Limited joint movement	_____
Psychiatric	_____
Anxious	_____
Depressed	_____
Hematological/Lymphatic	_____
Painful or enlarged glands	_____
Bruise easily	_____
Endocrine	_____
Diabetes	_____
Thyroid disease	_____

Anemia	_____
Angina/chest pain	_____
Arthritis	_____
Blood clots	_____
Blood transfusion	_____
Cancer	_____
Chronic headache	_____
Emphysema	_____
Glaucoma	_____
Hay Fever	_____
Head injuries	_____
Heart disease	_____
Mitral Valve Prolapse	_____
Heart Murmur	_____
Heartburn	_____
Hepatitis	_____
High blood pressure	_____
High Cholesterol	_____
HIV or AIDS	_____
Hives/ Rashes	_____
Keloid scarring	_____
Kidney disease	_____
Liver disease	_____
Pneumonia	_____
Poor wound healing	_____
Prolonged bleeding	_____
Reflux	_____
Seizures	_____
Skin ulcers	_____
Stomach ulcer	_____
Stroke	_____
Swelling/sore of ankles/feet	_____
Tuberculosis	_____

Pharmacy

Name: _____

Address: _____

Telephone: _____

Fax: _____

Other _____

David M. Vernick, MD, FACS

Harsha V. Gopal, MD, FACS

E. Ashlie Darr, MD

Name: _____

Date: _____

ACCT# _____

SINO-NASAL OUTCOME TEST (SNOT-22)

1. Directions: Circle corresponding number (1,2,3,4,5). Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: ☐☐	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Nasal obstruction	0	1	2	3	4	5
5. Loss of smell or taste	0	1	2	3	4	5
6. Cough	0	1	2	3	4	5
7. Post - nasal discharge	0	1	2	3	4	5
8. Thick nasal discharge	0	1	2	3	4	5
9. Ear fullness	0	1	2	3	4	5
10. Dizziness	0	1	2	3	4	5
11. Ear pain	0	1	2	3	4	5
12. Facial pain/pressure	0	1	2	3	4	5
13. Difficulty falling asleep.	0	1	2	3	4	5
13. Wake up at night	0	1	2	3	4	5
15. Lack of a good night's sleep	0	1	2	3	4	5
16. Wake up tired	0	1	2	3	4	5
17. Fatigue	0	1	2	3	4	5
18. Reduced productivity	0	1	2	3	4	5
19. Reduced concentration	0	1	2	3	4	5
20. Frustrated/restless/irritable	0	1	2	3	4	5
21. Sad	0	1	2	3	4	5
22. Embarrassed	0	1	2	3	4	5

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Name: _____ Today's date: _____

Date of Birth: _____

Epworth Sleepiness Scale

Answer how likely are you to doze off or fall asleep in the following situations.

Answer how you felt over the past week or so.

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

- | Number | Question |
|--------|---|
| _____ | 1. Sitting and reading |
| _____ | 2. Watching TV |
| _____ | 3. Sitting inactive in a public place (e.g. theater or meeting) |
| _____ | 4. As a passenger in a car for an hour ride without a break |
| _____ | 5. Lying down to rest in the afternoon, when able |
| _____ | 6. Sitting and talking to someone |
| _____ | 7. Sitting quietly after a lunch, without alcohol |
| _____ | 8. In a car, while stopped for a few minutes in traffic |

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ACCOUNT # _____

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

NAME _____

DATE OF BIRTH: _____