David M. Vernick, MD, FACS *Harsha V. Gopal, MD, FACS* *E. Ashlie Darr, MD*

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1244 Boylston St, Suite 303
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Tel 617-383-6800 Fax 617-383-6801

Date: _____ **New Patient Registration 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 PHYSCIANS that should receive notes from our office

1. Name: _____ Address: _____

Telephone _____ Specialty: _____

2. Name: _____Address:_____

Telephone: _____Specialty:_____

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Acct# _____

Background Information

Please check as appropriate. **Federal Government Information Requirement**

Preferred Language: ☐ English ☐ French ☐ Japanese ☐ Spanish ☐ Chinese ☐ Other _____

Patient Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ Caucasian/White ☐ Other/Unspecified

Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other/Unspecified

Social History

Alcohol Use: ☐ Never ☐ Moderate ☐ Occasionally ☐ Social # Drinks per week: _____

Exercise Regularly: ☐ Yes ☐ No

Exposure to Fumes, Dust, Solvents or Airborne Particles: ☐ Yes ☐ No ☐ none known

Recreational Drug Use: ☐ Never ☐ Former ☐ Current

Smoking History: ☐ **Current** Every Day ☐ Current Some Days ☐ Former Smoker ☐ Never Smoker

Of Years of Active Smoking: _____ Years since quitting: _____

Other Tobacco Use? (Pipe, Cigars, Chew): _____

Pharmacy Information

Local Pharmacy Name: _____

Street Address: _____

City: _____ _____ State: _____ Zip: _____

Phone #: _____ _____ Fax #_____

Mail Order Pharmacy Name: _____ Mail Order ID: _____

Telephone # _____ Fax #: _____

Pharmacy Preference (please choose) Local Pharmacy: ☐ Mail Order: ☐

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Reason for TODAY's visit: _____

Acct # _____

Surgical History

Have you had a tonsillectomy? Yes No Year: _____

Cancer: Specify _____

Cardiac: Specify _____

Cosmetic: Specify _____

Ear Surgery: Specify _____

Nose Surgery: Specify _____

Throat Surgery: Specify _____

Other Surgery: _____

Family History

Illness/Condition	Father	Mother	Brother	Sister
Family History Unknown: Check box				
Abdominal Aortic Aneurysm				
Alzheimer's Disease				
Behavioral/Emotional Health				
Bleeding Disorders				
Brain/Nervous System				
Cancer				
Diabetes				
Hearing Loss				
Heart/Cardiovascular				
Genetic Disorders				
Migraines				
Respiratory Disorders				
Stroke				

Have you ever had a pneumonia immunization? Please circle one: Yes No Unknown

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Past Medical History

(Check the box to the left of the condition that you are currently being treated for or have been treated for in the past)

	Allergies (Seasonal/Environment)		Deep Vein Thrombosis (DVT)		Low Blood Pressure
	Anemia		Depression		Lupus
	Angina		Dermatologic (Skin)Disease		Lyme Disease
	Acid Reflux		Diabetes		Lymphoma
	Asthma		Diverticulosis		Melanoma
	Atrial Fibrillation		Eye Disease		Mitral Valve Prolapse
	Auto-Immune Disease		Gallbladder Problems		Myocardial Infarction
	Behavioral Disorder		Gastrointestinal/GI Problems		Neurological Problems
	Bleeding Disorder		GERD/Reflux		Neuropathy
	Blood Clots		Hepatitis		Pneumonia
	Cancer		Head Injuries		Renal Disease
	Chronic Fatigue Syndrome		Headaches (migraine, cluster)		Rhinitis
	Cardiovascular (Heart Disease)		Hearing Loss		Seizure Disorder
	Chronic Heart Failure (CHF)		High Blood Pressure (Hypertension)		Sinus Problems/Sinusitis
	Congenital Heart Disease		High Cholesterol		Transient Ischemic Attack (TIAs)
	COPD/Emphysema		HIV/AIDS		Thyroid Disease
	Coronary Heart Disease		Insomnia		Tuberculosis
	Crohns Disease		Kidney/Urinary Bladder Problems		Ulcers (other)
	Cerebral Vascular Accident (CVA)		Liver Disease		Ulcers (stomach)

None of the above applies: ☐ check here

Review of Symptoms (ROS):

Identify which if any of the following you are currently experiencing:

√		√		√	
	Abdominal Pain		Frequent Nose Bleeds		Rash
	Anxiety		Headache		Shortness of Breath
	Cough		Heartburn		Skin Lesions
	Depression		Hoarseness		Sore throat
	Difficulty Hearing		Joint/Muscle Pain		Vision changes
	Difficulty Sleeping		Nausea		Weight gain/loss
	Difficulty Swallowing		Noises in Ear/Head		Wheezing
	Fainting		Pregnant		

Other Symptom(s) Not Listed: _____

_____

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Medication History

Please list all medications that you're taking including over-the-counter medications, vitamins and other treatments. Please attach your medication list if more convenient.

Name of Medication Include over the counter medications	Dosage (mg/units/puffs/drops)

Patient reviewed and acknowledges that they are not taking any medications at this time: ☐ check here

Drug, Food and Latex Allergies

Drug Allergies: □ No □ Yes

If yes, please list Drug name and reaction:

Drug Name: _____ Reaction _____

Drug Name: _____ Reaction: _____

Drug Name: _____ Reaction: _____

Latex Allergy: □ No □ Yes Reaction: _____

Shellfish Allergy: Yes ☐ **No** ☐

Other Food Allergies: _____

Patient/Physician Acknowledgement Signatures

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____