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

Vernick and Gopal, LLC
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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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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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: ______________________________

____

Reason for TODAY's visit: ______________________________

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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 recent 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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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 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: ______________________

Patient/Physician Acknowledgement Signatures

Patient Signature: ______________________ **Date:** __________

Physician Signature: ______________________ **Date:** __________